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Foundation Year 2 doctors' reasons for leaving UK medicine: an in-depth analysis of decision-making

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Foundation Year 2 doctors' reasons for leaving UK medicine: an in-depth analysis of decision-making

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Data sharing statement: Additional data is available by emailing sam.smith@ed.ac.uk

ABSTRACT

Objectives: To explore the reasons that doctors choose to leave UK medicine after their foundation year two posts

Setting: All four deaneries in Scotland

Participants: Foundation year two doctors (F2s) working throughout Scotland who were considering leaving UK medicine after foundation training, were recruited on a volunteer basis. Maximum variation between participants was sought.

Primary and secondary outcome measures: Semi-structured interviews were coded using template analysis. Six perspectives, described by Feldman and Ng, were used as the initial coding template. The codes were then configured to form a framework that explores the interplay of factors influencing F2 doctors' decisions to leave UK medicine.

Results: Seventeen participants were interviewed. Six perspectives were explored. Structural influences (country-wide and world-wide issues) included visas, economic and political considerations, structure of healthcare systems, and availability of junior doctor jobs worldwide. Organisational influences (the NHS and other healthcare providers) included staffing and compensation policies, the working environment and the learning environment. Occupational influences (specific to being a junior doctor) comprised the junior doctor contract, role and workload, pursuit of career interests and the structure of training. Work-group influences (relationships with colleagues) included support at work, task interdependence and use of locums. Personal life influences consisted of work-life balance, and support in resolving work-life conflict. The overarching theme of "taking a break" recurred through multiple narratives.

Conclusions: For a variety of complex and individualised reasons, F2s are choosing to leave the UK after foundation training. Whilst some of their reasons might be amenable to changes in the UK, many F2s may still choose to go abroad to experience a specific specialty, to explore the world, to pursue altruistic motivations, or simply to gain a new experience. We should plan for F2s to leave, and make the UK healthcare system a desirable place for them to return to.

STRENGTHS AND LIMITATIONS

- This study explores the in-depth views of Scotland-based F2 doctors regarding their training experience and their ideas about junior doctor jobs abroad. It explores their

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4 explicit reasons for leaving, as well as some factors known to increase job mobility, in
5 order to uncover some of the hidden reasons for junior doctors leaving the NHS.

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- This study fills a gap in the literature, as there have been few studies exploring the subject, and no previous qualitative studies examining this issue.
 - A constructivist approach was used, and therefore the results do not attempt to predict the future, but instead explore the intricacies of decision-making, and provide a springboard for further areas of research.
 - The F2s had a broad range of specialty interests, range of destination countries, country of origin, and both genders were represented. However, the age range was narrow and all F2 were based in Scotland. The results may therefore be transferable to other contexts but are not generalisable.
 - While every attempt was made to put participants at ease, and create a non-threatening environment, the F2s may have wanted to present a certain image of themselves to the researcher, and may have chosen to hide some of their reasons for leaving accordingly.

20 21 INTRODUCTION

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23
24 The Foundation Year 2 (F2) Career Destination Report 2016 showed that only 50.4% of UK
25 F2 doctors progressed to UK specialty training, a year-on-year decrease from 71.3% in
26 2011, 67.0% in 2012, 64.4% in 2013, 58.5% in 2014, and 52.0% in 2015.¹ Between 2010
27 and 2013 the numbers of UK doctors applying for a General Medical Council (GMC)
28 certificate of good standing, enabling them to work abroad, increased by over 16% from
29 4080 to 4741.² The F2 Career Destination Report provides further evidence that many of
30 these applicants are F2 doctors: in 2015, 10.8% had secured or intended to secure
31 employment as a doctor outside the UK.¹

32
33 As F2 doctors move abroad, take career breaks or leave the profession altogether, UK
34 medicine is left in a state of crisis, with 12% of GP specialty training posts unfilled in 2014³
35 and 17% of Scottish GP practices reporting at least one vacancy.⁴ The Scottish
36 Government have recently announced that there will be 100 new GP training places this
37 year,⁵ but given the large numbers of F2s leaving the UK, it may not be possible to fill these
38 places. The detrimental effect of the exodus might be mitigated to some extent if many of
39 the doctors who leave after foundation training subsequently return to UK medicine.
40 However, evidence suggests this is often not the case: a questionnaire study of UK doctors
41 who had settled permanently in New Zealand showed that only 30% had originally intended
42 to stay long term, suggesting that despite the majority of doctors having intentions to return
43 to the UK when they initially move abroad, many do not do so.⁶

44
45 There is a surprising lack of research into the reasons why doctors decide to leave UK
46 medicine. Two studies have attempted to gain such insights using questionnaires. Moss *et al.*
47 sent a postal questionnaire to a group of UK graduates in 1999, approximately a year
48 after graduation.⁷ Of the 4221 graduates, 2727 responded. Sixteen percent of respondents
49 indicated that they were probably or definitely not going to continue to practice medicine in
50 the UK. The main reasons cited included working conditions and lifestyle factors.⁷ Sharma
51 *et al.* sent a questionnaire to UK doctors who had settled in New Zealand in 2012.⁶ Out of
52 419 doctors sent the questionnaire, 282 responded. The majority of respondents (69%)
53 stated that their reason for moving was for a clinical job.⁶ Other reasons included seeking
54 other work, for a holiday, to spend time with family or friends, better lifestyle in New Zealand,
55 or disillusioned with the NHS or with life in the UK. Thus, the reasons for moving abroad
56 were similar to those found in 1999, relating to perceived poorer working conditions in the
57 UK and perceived improved lifestyle abroad.

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These studies were carried out prior to the sharp increase in the proportion of F2 doctors opting to leave UK training. It is therefore timely to re-examine this significant and growing issue, to understand more fully the reasons underlying the increased numbers of F2 doctors leaving UK medicine. Furthermore, there have not been any qualitative studies which have aimed to characterise the reasons for F2 doctors leaving UK medicine (beyond the short generic stems used in questionnaire-based studies), or which have investigated the relative influences of the salient factors on doctors' decisions to leave.

Research Aims

The aim of this interview study was to explore F2 doctors' reasons for leaving UK medicine, in order to better understand how they might be encouraged to stay.

METHODS

Philosophical assumptions

This research required a constructivist approach, in order to explore in detail the decision-making processes of F2 doctors. As per Guba and Lincoln's description of the metaphysical paradigms, the following philosophical assumptions were made: 1. The ontology is relativist (there is no objective reality) 2. The epistemology is transactional and subjectivist (truth is constructed by the researchers through interactions with the world) 3. The methodology is interpretative and explanatory, rather than experimental.⁸ The result of this research will *not* be a definitive explanation of why F2 doctors leave UK medicine, but will instead be an exploration of the myriad of factors influencing decision-making.

Framework

While there have been limited studies examining the reasons that F2 doctors choose to leave UK medicine, there has been research examining "*career mobility*" versus "*career embeddedness*" in professionals in general.⁹ Feldman and Ng (2007) examined the pertinent literature and assimilated it into six perspectives that influence career mobility versus embeddedness. In brief, these perspectives were as follows:

1. The structural perspective: Macroeconomic factors and social and legal factors, for example, the number and quality of jobs available. UK-wide or worldwide factors which are not specific to a single profession.
2. The organisational perspective: Organisational staffing and compensation policies. Any organisational policy that affects all the workers within that organisation.
3. The occupational perspective: Salary and workload. Organisational policies which affect a specific occupational group.
4. The work group perspective: Social connections and interactions that professionals have, both within their own organisation and between different organisations.
5. The personal life perspective: The impact that the non-work part of a professional's life has on their decision to move (such as friends and family). Includes work-life balance, and how the impact of work on personal life influences an individual's decision-making.
6. The personality perspective: The impact of personality types such as the "big five" or attachment styles on career mobility versus embeddedness.⁹

Feldman and Ng's six perspectives represent an appropriate starting point for this study, because the factors above resonate with both the authors' experiences within medicine and the previous research detailed above.^{6,7}

Ethical approval

The need for full ethical approval was waived by the research ethics committees in South East Scotland, East of Scotland, North of Scotland and West of Scotland.

Data collection

Participant recruitment

At the time of this research, there were contentious proposed changes to junior doctor contracts in England resulting in strike action by junior doctors.¹⁰ These recently-proposed contractual changes would inevitably have been the focus of conversation had the study recruited doctors currently working in England. For these reasons, this study focussed on F2 doctors currently working in Scotland.

Doctors who planned to leave UK medicine on completion of foundation training were recruited on a volunteer basis. Participants were invited via a notice in the Scotland-wide Foundation bulletin, a message in the Foundation trainee e-portfolio, a notice in the BMA Scotland junior doctors committee newsletter, opportunistically in the workplace and at medical education conferences, using social media and through snow-ball sampling.¹¹ Volunteers who showed interest in participating were sent information about the study and then decided whether or not to participate. Those who did participate completed consent forms.

Maximum variation was sought, with the aim of including participants from all Scottish deaneries, both genders, a variety of proposed destinations, a variety of nationalities, a variety of career interests and as broad an age range as possible. Whilst acknowledging that saturation is always a “*matter of degree*”,¹² data collection ceased when the new data generated did not add to the overall framework.

Semi-structured interviews

A single researcher (SS) conducted online-video semi-structured interviews with participants, to explore their reasons for leaving UK medicine. The researcher is a female GP with a medical education doctorate, with experience of qualitative research interviewing both during her doctorate and subsequently. Prior to interview commencement, participants were informed of the researchers’ background, purpose of the research, and were invited to ask any questions.

The interview structure was based on the factors identified by Feldman and Ng.⁹ During the interviews, particular attention was paid to eliciting rich descriptions of the decision-making process including the factors involved and the ways in which salient factors were identified and assimilated. Data analysis was carried out in tandem with collection, in order that new themes could be expanded and explored in subsequent interviews. Interviews were audio recorded, transcribed verbatim and anonymised. Field notes were taken during interviews when required. Participants received a £20 Amazon voucher as recompense for their time.

Data analysis

Initial data analysis was undertaken by SS using template analysis.¹³ In template analysis, the codes are generated both ‘a priori’ and inductively, during the analysis.¹³ The framework provided by Feldman and Ng’s literature search⁹ was used for the initial template, but this was later modified and amplified by the data. Data were coded in Microsoft Word by SS

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4 then reviewed by one of three additional researchers, to check for other interesting codes
5 and themes that may not otherwise have been identified. The codes were renamed,
6 reshuffled and redefined to ensure resonance with the data and overall coherency. The
7 codes were then configured to form a framework that explores the interplay of factors
8 influencing F2 doctors' decisions to leave UK medicine.
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10 RESULTS

11 Participants

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14 Nineteen interviews were scheduled and 17 took place (two participants failed to respond
15 after initially showing interest). Of the 17 participants, 12 were women and five were men.
16 Six were from the South East deanery, five from the East, three from the North and three
17 from the West. Five planned to go to Africa (South Sudan, Uganda, South Africa), 11
18 planned to go to Australia or New Zealand and one planned to go to Europe (Germany).
19 Eight planned to ultimately apply for medical specialties, three to surgery, one to psychiatry,
20 two to obstetrics and gynaecology and three were undecided. Eight were Scottish, three
21 were English, one was Northern Irish, one was Welsh, one was from Africa, one from
22 Singapore, one from Malaysia and one from Hong Kong. All participants were aged 24-27
23 and all had studied medicine in the UK.
24

25 Interviews

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27 All interviews were conducted online with video (FaceTime or Skype). Participants were
28 interviewed in their own homes. Only the interviewer and participant were present.
29 Interviews lasted, on average, 42 minutes (28 to 65 minutes). Repeat interviews were not
30 required.
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32 Coding framework

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34 The resultant coding framework is explained in tables 1-5, below. The personality
35 perspective is not included in this paper, as it is not amenable to intervention. Any themes
36 deemed not amenable to intervention (for example, climate, influence of friends and family or
37 personal interests) are also excluded from this analysis. Themes that discouraged doctors
38 from visiting certain countries (for example, needing extra exams or concerns about personal
39 safety) were also not included in this analysis.
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Table 1: Structural perspective

Subtheme	Details	Illustrative quote
<i>Moving to another country in general</i>		
Visas	F2s reported that Australia and New Zealand made it relatively easy for them to navigate the process. UK visa rules were cited as a reason for leaving the UK	"...if I wanted to do that [locum for six months in the UK], I couldn't, I need an actual job that I'm doing for the whole year to be able to stay." (P12)
Economic and political considerations	<p>The Scottish independence referendum Financial uncertainty brought about by the recent Scottish independence referendum was cited as a reason to move abroad now. Some participants stated that if Scotland were to become independent, this might put them off returning to the UK</p> <p>Britain's exit from the EU Britain's exit from the EU was seen as a potential future barrier to working in EU countries, but did not influence the decision to go now</p>	<p>"If things stayed as they are just now, I would come back quite easily. But, if Scotland was to become independent that would be a trickier one. Where are they going to get the money from to fund the budget? ... So, if that was to happen then it would be a bit more difficult to come back." (P3)</p> <p>"I was shocked, to see the news [about the UK's decision to leave the EU]. But I guess it won't happen for another two years, at least. And hopefully that wouldn't affect my chance of finding a job, because I'm going now, instead of in two years. Where I think for people after me, then it might not be as easy actually, to find a job abroad, especially in Europe." (P14)</p>
<i>Moving to another country as a doctor</i>		
Structure of healthcare systems	Certain healthcare systems, such as Malaysia, Singapore, Canada and the United States, were seen as undesirable to work in. Reasons included long working hours, poor training opportunities, rural placements and health inequality. Some F2s felt that different healthcare systems helped the public to value healthcare professionals more	"I suppose medics are viewed in a better way, just more respect. The patients probably pay a bit of insurance and they do have to take accountability for their own health care and that way they do then value all the healthcare professionals more, not just the medics." (P6)
Availability and quality of junior doctor jobs in the world	Many of the F2s had found it relatively easy to get the job of their choice, and quantity of jobs in their destination country was not seen as an issue. Some F2s felt that the quality of available jobs in their destination country was low, but this was not a big concern, as their reasons for leaving were not necessarily to seek quality training opportunities	"My impression is that basically you end up with the jobs that no-one else wants from Australia or New Zealand. Quality-wise you're probably ending up in a job that is less good than you would get in the UK but as a friend of mine put it to me you're not going there really for the clinical exposure... most people are going there because they want a different experience." (P1)
Type of patients and medicine encountered	The typical NHS patient was viewed by some as a "chronic disease patient", with many climate and lifestyle related conditions. Going abroad was, for some, a way of experiencing different types of medicine	"I'm really hoping that I get a snake bite, just because that'll be the moment that I've made it in Australia. I know there's quite interesting cultural issues to medical problems. So the Aboriginal population has a huge alcohol problem... And they have different problem drugs, to here as well, so like, crystal meth. Stuff like that will be really fascinating to learn about." (P15)

Table 2: Organisational perspective

Subtheme	Details	Illustrative quote
<i>Staffing and compensation policies</i>		
Location of jobs	Current staffing policies result in F2s not necessarily working in the region of the UK in which they would prefer to live	"As much as I love being here, I feel it is not a very attractive region within the UK. It's probably the bottom of the pile." (P6)
Rota gaps	Most of the F2s had worked in jobs in which there were rota gaps, and most had been asked to increase their hours to fill these gaps	"All my previous rotas, they've never been fully staffed... we were three down at one point, and we just had to cover the bulk of that. And we sent emails saying, this is so unsafe, but you don't really get very far with that." (P4)

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Rota policies	In Australia, it was possible to pair rotas with a partner	<i>"One perk of Australia, the pairing, or more consideration to the rota. They're not fully linking mine, but they're going to match when we're working weekends."</i> (P15)
Perks	Australian organisations were thought to have good perks compared with the NHS, which contributed to the sense of feeling valued. Having somewhere to go during breaks, such as a doctors' mess was felt to be important	<i>"It's kind of hard to take a break and dissociate yourself from work when there's nowhere to go."</i> (P2)
Working environment		
Feeling valued	Many of the F2s felt that Australian and New Zealand organisations valued their staff more than the NHS did	<i>"How often have you stayed overtime and got no...no one thanks you for it. You get upset because you're hungry, tired, haven't gone to the toilet and you're never getting paid for it."</i> (P10)
"Non-handoverable jobs"	F2s described staying late at work for jobs that were "non-handoverable". These were jobs that were not urgent but they did not feel they could hand over to the next shift	<i>"It's things like ordering bloods for tomorrow. Things you know that should have been done during the day. But sometimes, you're just so busy, it doesn't get done.."</i> (P10)
Working atmosphere	The working atmosphere within the NHS was felt to be very negative. The working atmosphere in Australia was thought to be more relaxed than in the UK	<i>"The Australian people's personalities are very relaxed and very chilled, so a lot of people have said that that it's a nice environment to work in. In that sense I think it could differ between that and the UK."</i> (P11)
Raising concerns	F2s were unsure about how to raise concerns and were worried that they might be penalised for doing so	<i>"How are you supposed to give any of this feedback to the top people, because where on earth are they? I think also sometimes you're worried if you had a concern and you expressed it, that number one, it would fall on deaf ears, and also would you be getting into trouble for expressing concerns?"</i> (P9)
Learning environment		
Learning on the job	F2s enjoyed being challenged, and this was viewed as a positive part of the learning process. Going abroad was viewed by the F2s as good for on the job training	<i>"You can tell people who have been away, and have come back. Just, they're much more confident, they've got much more experience."</i> (P4)
Formal teaching	Australia had a reputation for providing more formal teaching than that which is offered in the UK	<i>"One of my friends who is working out in Perth [Australia], has said actually she has like hourly sessions kind of every other week where she'll get bedside teaching. That's way above and beyond what I've had. I don't think I've had bedside teaching beyond what happens on a ward round."</i> (P13)
Mentorship	Most of the F2s would have liked to have a mentor, had that been available to them	<i>"My consultant [in a previous job] was very good in encouraging and looking at options and she was probably the person who gave me the most advice about careers. I found that immensely useful, so I think to have some kind of continuity with someone who could be a mentor would have been probably very helpful."</i> (P8)
Careers advice	Some F2s stated that they had received little or no careers advice. Others were satisfied with the careers advice that they had been given	<i>"I think most of the time people expect you to just figure out on our own what you want to do and get the advice that you want on your own."</i> (P12)
Balance of service provision versus learning	Some of the F2s felt that there was a greater emphasis on service provision than on training	<i>"When I was in gen med, there could have been opportunities to observe lumbar punctures, do more pleural taps and things. But we just had to do so many discharge letters and referral forms. And I mean, it just wasn't helpful for our training."</i> (P10)

Table 3: Occupational perspective

Subtheme	Details	Illustrative quote
The junior doctor contract, role and workload		
Salary	Salary was unimportant to many of the F2s, to the extent that some did not even know how much they would be paid in their future roles. Others were hoping to have a higher salary, with opportunities for saving money. For many, a higher salary was a "nice bonus" rather than a reason for going	"I would say it's an added bonus, I would say if they were going to say you will get paid the same as you are just now, I would still go." (P3)
Proposed changes to contracts in England	The proposed changes to junior doctor contracts in England had unsettled the F2s. They had mixed feelings about going away during a time of uncertainty, and concerns about what it might mean for them if they chose to return to the UK One of the F2s had considered applying to specialty training in England, but had decided instead to apply to Australia, partly as a result of the proposed changes to junior doctor contracts in England	"I think if I worked down there [in England] I'd be totally disheartened and wouldn't really want to continue. Sometimes I think I probably wouldn't want to do this job if I was paid any less... And it'll definitely change my perception if I come back and Scotland's gone the same way, what will I do?" (P2) "I always wanted to work in London, so if I was applying for CMT1, I would have liked to have apply down South. [But] there was a lot of uncertainty and there's still a lot of uncertainty now about what the contracts are going to be like. I think they have started releasing the provisional contracts now and they look terrible. You've been paid less and you're working a lot more and you're working one in two weekends. It didn't seem like a good thing to trade rather than working somewhere where there is a good work life balance and sunshine and people appreciate what you do for a living in Australia - why would I want to move to England?" (P12)
Labour intensity	In general, labour intensity was felt to be high in F2 posts, which was exacerbated by understaffing F2s had heard that the labour intensity in Australia and New Zealand was lower	"We have a lot of staff shortages. Usually there's only one of us on the ward. You feel like you're fighting fires a lot of the time." (P1) "From what I hear it's meant to be slightly less intense particularly in A&E, as I read a few articles. People definitely say you are less stressed because you've just got more people on the shop floor." (P1)
Junior doctor skills		
Transferability of skills	F2s described the development of transferable skills which would help them in their future jobs Some F2s did not feel adequately prepared to enter specialty training directly	"I find now I'm less afraid of difficult conversations with families or patients. You have to be better at prioritisation and organising your time. Also trying to delegate to other people and knowing when it's appropriate to call for senior help." (P1) "When I see people go and start their CMT [core medical training], they cover CCU [the coronary care unit] and renal on their nightshift. It's funny because at the moment I'm the one calling them about this abnormal ECG [electrocardiogram], but then you think, God, in four months' time I'm the one who is getting called... that sounds awful. I think maybe I am just not quite ready to go into CMT yet." (P9)
Pursuit of career interests		
Specific clinical job	Some F2s were going away for a specific clinical job, which they could not do in the UK	"I only wanted to go to New Zealand if I was going to get a particular job in a particular department... I've got a registrar job as a haematologist out there... If I stayed here in the UK I would have had to just apply for CMT, and because haematology is a bit more of an unusual speciality, quite a lot of CMT trainees don't even get to do any haematology, and I would only get to do four months of it anyway." (P9)
Further study and research	Some of the F2s planned to spend part of their time after F2 completing further study or research	"I am spending the first three months doing a tropical medicine diploma..." (P5)

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	Travel was seen as a potential way of building relationships for future research collaborations	<i>"I think it would probably be good for your career to have a wider experience, wider contacts, certainly academically bigger scope for collaboration."</i> (P16)
Structure of training		
Rigidity of training structure	Some of the F2s would like to have completed one year abroad, but planned to complete two years due to the inconsistencies between the British and Australasian year turnover F2s who wanted to enter specialties with long run-through programmes were motivated to spend time away after F2, as it may be their last chance in a number of years	<i>"The Australian medical year starts in January whereas the British one starts in August it does mean that if you end up with say a 12 month job starting in January it would be difficult to come back within one year. So, one year may be two."</i> (P1) <i>"I want to do obstetrics and gynaecology. It's run through for eight years, so it's a long commitment and there will be no opportunity to go abroad at all during that. We'll be contract free from August, so we can actually go away. It's basically the only time."</i> (P7)
Deferred entry schemes	Many of the F2s would have considered applying for deferred entry schemes, had they been available	<i>"I would have applied for CMT and GP and, you know, that would have meant that, A, it would be nice to know that you've got that certainty of having a job at the end of the year and, B, it would mean not having to come home at Christmas time for applications."</i> (P8)
Choosing a specialty	Some of the F2s stated that their main reason for going abroad was that they had not decided which specialty they wished to apply for, or were not yet certain. One F2 would like to have applied for a "broad based training" scheme, rather than decide on a specialty at this stage One F2 felt that she had decided too late on her specialty application, and wanted more time to appropriately build her CV	<i>"Part of the reason why I'm taking a year out is I couldn't decide between different specialities... I'm really buying myself a bit more time."</i> (P1) <i>"The broad based training that they had down South, it was never introduced in Scotland, but that had paediatrics, GP, medicine and stuff in it, and I considered that for a while, just to delay the decision-making process."</i> (P5) <i>"I maybe know what I want to do in the long-term but need to be more set on it. I had done my interview ages ago, and I wasn't even ready for that at all. My CV wasn't built up well enough either, I needed the extra few months to do it. And I'll try and use the next two years to do that as well."</i> (P2)
Conveyor belt / treadmill of training	Some of the F2s described feeling like they were on a "conveyor belt" or "treadmill" of training, and felt that post-F2 was a good opportunity to step off for a while	<i>"You are on this conveyor belt, you're 17 and then you've signed up for life. I think, for me, it was just the last couple of years, you realise what you've actually committed to. If I commit to a training programme, that's six years or so and after that you are looking at trying to get consultancy posts quite quickly. I would think on that kind of timescale you are thinking about family and mortgages... I don't think you can really travel. This is an opportunity to go away for so long whilst still maintaining your clinical practice."</i> (P6)
E-portfolio and WPBAs	The F2s felt that the e-portfolio was cumbersome to complete and too vague to be useful	<i>"A lot of the way the training is done now, with all the log books and competencies and all this kind of stuff, is exhausting and boring."</i> (P16)
Four-month rotations	One of the F2s described a dislike of short rotations and a desire to stay in one place for a longer period of time	<i>"I'm fed up of changing jobs every four months. I'm doing obs and gynae at the moment and I'm really enjoying it but it took me three months to start to feel like I was comfortable dealing with all the obstetric stuff and getting into the groove of going to theatre, and then I'm changing in less than a month.."</i> (P17)
The need to reapply and threat of relocation	One of the F2s described a dislike of the UK system in which it is necessary to reapply for jobs every two years, with a threat of relocation to another area of the UK	<i>"I actually think that I'm quite a scared person, and I don't like changes. Even if you get into an ST1, you would have to compete again to get an ST3 position. What if you have to move across the country? It's just so unstable, the life in Britain, I'd rather compete once, and get a job, and you're just allowed to stay there for five years."</i> (P14)

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Table 4: Work-group perspective

Subtheme	Details	Illustrative quote
Support at work	Other junior doctors were viewed as the most important social relationships at work	<i>"You're working with the same big bunch of people. So, you get to know quite a lot of people. It was a really good sized job actually for me, for making friends and creating like a social circle. I actually did quite enjoy it."</i> (P13)
	Loneliness at work, in particular a lack of contact with other junior doctors, affected their enjoyment at work	<i>"I think also it's been quite a lonely job because you are by yourself a lot of the time. We don't have F1's. We don't have registrars. I didn't realise how much that can affect your job satisfaction... because thinking back all the other jobs I've had have been in really big teams and perhaps even when we were busy and it was maybe a bit stressful you could moan about it to somebody else and the loneliness affects you I think..."</i> (P1)
	Lack of support from seniors affected their enjoyment at work	<i>"In neurosurgery the registrars weren't very... they're not a very supportive bunch. There's someone suddenly blowing a pupil and you're like, is this person dying? What am I going to do? They'd be like, 'I'm busy, sort it'."</i> (P3)
	Bullying from senior doctors was an issue for some	<i>"I was sitting flicking through a massive set of notes and then the consultant walks round the corner and goes; 'What are you doing?' and shouts at me in front of all the nurses, everyone on the ward. Then when you get a bit tearful tells you to grow up in front of everyone, very publically. Numerous occasions like that, particularly in surgical jobs. Just being made to feel that you're never good enough and never getting any thanks for what you do. I don't know for sure that that's different in Australia, but from all the feedback I've got from everyone that's in Australia and New Zealand working at the minute it appears to be quite a bit different."</i> (P2)
	Lack of support was not universal. Some of the F2s experienced good senior support at work	<i>"From a service provision point of view, I felt very well supported. I've always had seniors around to ask for help, even on my surgical jobs..."</i> (P13)
Task interdependence	Many F2s had heard that there was good support from senior staff in Australia and New Zealand	<i>"From what I've heard it is very consultant heavy... I don't think I'll be left as alone as I am here. I think if I'm on call, there will always be a registrar around, and again there will be juniors below me."</i> (P3)
	Poor relationships with the nursing staff affected enjoyment at work in at least one case	<i>"The nursing staff wouldn't listen to me. They would then go and get consultants and run everything I did past them. There are some strong characters in that department and it's well known that that is the case. I just clashed with them and I find it quite condescending and made me feel like, that you weren't a doctor, that you are more a medical student because everything you said had to be verified by a consultant."</i> (P9)
	F2s did not worry that their leaving would impact on their colleagues, and felt that in some ways it may advantage F2s who chose to stay	<i>"If you look at people leaving as a whole it will make the jobs easier to get in some ways because they'll have less competition. It's different if you're leaving a rota, if you're already in a training position, but it shouldn't affect my colleagues because I've no obligation to be there in that hospital."</i> (P7)
Use of locums	They felt that their going away on a "gap year" had a small effect when compared with the "underlying problem of not enough people"	<i>"I maybe haven't thought about it but I'm contributing to that gap... whilst I very much am aware that I am trying to justify it's okay for me to go away and I'm not going to screw everybody over...for next year, I think that the underlying problem is there just not enough people. I think people taking a break is... relatively negligible to the fact that there just aren't enough bodies..."</i> (P6)
	Working with locums was generally viewed unfavourably	<i>"Sometimes you can get people that are completely new to the specialty and healthcare around the UK or even healthcare at all and that can be more challenging. They're at my level and they're filling up a gap in my rota slot at my level but at the same time I find them depending on me...which can be a bit difficult."</i> (P16)

Table 5: Personal life perspective

Subtheme	Details	Illustrative quote
Work-life balance		
Work-life conflict	Some of the F2s described a poor work-life balance in their current NHS roles	<i>"I've missed friends' weddings, I've missed a christening, I missed my grandmother-in-law's funeral because I couldn't get the time off work."</i> (P5)
	The F2s expected there to be less work-life conflict in their roles abroad	<i>"I've spoken to people who are doing A&E there [in New Zealand], and it's very similar, but, less hours. So, they normally do four days a week, whereas, right now, I'm doing seven. I'm on seven days right now, and I'm working from either two or three, 'till midnight, every day. Next week, I'm going straight into nights. So that's two weeks that I cannot have any social life. In New Zealand, I can do the job for four days a week, and then have a nice weekend off."</i> (P4)
Work affecting health	The F2s recounted times when work had negatively affected their own or others' health	<i>"She [another doctor] says the quality of life out there [in Australia] is so much better. She said when she worked here she was always stressed out, quite anxious as well... Then when she went out there she felt more supported and had enough time off to relax. She feels like she's absolutely a completely different person because her work life now doesn't affect her personal life."</i> (P9)
Support in resolving work-life conflict	Some F2s had heard reports that work-life balance was better supported in Australia, through better handover arrangements and support from consultants	<i>"It's easier to leave on time [in Australia], because you know there's someone there to handover to and your consultant is there saying, go home, is what I've been kind of told."</i> (P3)
	They perceived a lack of support from the NHS in helping to resolve work-life conflict	<i>"We know for a fact that we have three vacancies coming up in our rota, and they've done nothing to try and fill them, because in the end they're just going to email round us, rather than getting a locum... and the thing is we do, we do still fill it because we need to, the patients need us."</i> (P9)

Overarching theme

One theme spanned many of the different perspectives, and recurred through multiple narratives. This was the theme of "taking a break". Examples are given in table 6, below.

Table 6: "Taking a break"

Subtheme	Details	Illustrative quote
Taking a break	A break from medical training (occupational)	<i>"It seems that a lot of FY2's that I know are quite burnt out, to be honest. People are tired of, I don't know if it's tired of working, but... you get into medical school and then it's five or six years and straight into foundation training and then you're probably working towards entering medical school for many, many years before you enter medical school. So everyone just seems to need time off."</i> (P12)
	A break from being a doctor (occupational)	<i>"I think the diploma in tropical medicine will probably be quite full on... but I'm not got people dying around me and having to sort them out, and then equally the six months of travelling is travelling, so I'm not going to be doing any work."</i> (P5)
	A break from thinking about career progression (occupational)	<i>"It's also a break from having to think about your career too much, especially if you want to go into a competitive speciality. There can always be a pressure on you that it's not just enough to do the day job -you have to get published, you have to do your audits, your posters, your presentations, there's extra courses and working everything into your CV and just all that general stuff, whereas I think if you practice medicine abroad...well, I certainly don't intend on pushing the seriously academic side of my CV too much when I just want to enjoy doing the job."</i> (P17)
	A break from the NHS (organisational)	<i>"I feel like I should have a break for a year and probably that will make me feel more enthusiastic about working in the NHS again afterwards."</i> (P1)
	A break from the UK (personal life)	<i>"I would just like to be away from this. And there are times, especially on my previous rota, where the job wasn't as good, and I was working all the horrible hours, and having horrible situations, I was just like, it would be so nice to just not have this. So I think it's just like a nice wee break."</i> (P4)
	A break from working (personal life)	<i>"I think it's about going and exploring a brand new place and having the ideal time in your career to take that break."</i> (P9)
	A break from the "hum drum" of life (personal life)	<i>"I'm only moving at the end of August. And the prospect of having more than two weeks of holiday is pretty amazing, actually. So I guess, not a huge, long break, but at least, something that's more than two weeks of holiday, is pretty good."</i> (P14)
	A break from the "hum drum" of life (personal life)	<i>"You're opting out of normal life... you're just pleasing yourself and educating yourself and branching out. [At home] you just get bogged down in work and then stuff like having the flat means that you have to maintain the flat. There's bills to pay. There's just the hum drum life and you just you have to deal with it, whereas with travelling you're just so much more free."</i> (P17)

DISCUSSION

In this study, we have used a framework provided by Feldman and Ng's 2007 literature review⁹ to explore the reasons that F2 doctors choose to leave the NHS after their F2 year. The use of this framework has allowed us to explore the breadth of their explicit reasons for leaving, but has also given an insight into the life of an F2 doctor in the NHS, thus possibly providing hints of some covert reasons that they may choose to seek work elsewhere. We will discuss some of the issues raised in each of the six perspectives, and the overarching theme of *"taking a break"*, and discuss what could be done to reduce the loss of junior doctors from the NHS.

The structural perspective

Obtaining work visas for Australia and New Zealand was perceived by participants as straightforward, whilst UK-trained doctors who were not UK nationals faced difficulties in obtaining a visa to stay in the UK. Given the large numbers of junior doctors now leaving the UK¹, the UK government could consider special arrangements to allow UK-trained doctors to stay should they wish. Previous research has suggested that in times of financial uncertainty, individuals are more risk averse and unwilling to leave.¹⁴ In contrast, the F2s in this study felt that the financial uncertainty brought about by the recent Scottish independence referendum and Britain's decision to leave the European Union made this a good time to go abroad.

The organisational perspective

"Feeling valued" was an important concept for the participants. This related to staff perks, but also to working hours and being thanked for doing their job. Something as simple as having a dedicated space to go to during their breaks made doctors feel more valued, though in many hospitals the doctors' mess has been abolished.¹⁵ This is reiterated in the literature on employee engagement. Seijts and Crim (2006) describe the *"Ten Cs of Employee Engagement"* as including connect (make employees feel valued), career (provide challenging and meaningful work with opportunities for career advancement), clarity (a clear organisational vision and goals), convey (provide feedback to employees on their performance), congratulate (thank and praise employees), contribute (help employees to understand the value of their contribution), control (give employees opportunities to control the pace and flow of their work), collaborate (provide opportunities to work in teams), credibility (maintain the good reputation of the company) and confidence (have leaders inspire confidence in their employees).¹⁶ Of these "Ten Cs", several were brought up by the F2s. For example;

Connect: *"In Australia... they provide you with parking spaces, food, free tea or coffee..."* (P2)

Congratulate: *"It's very rare to get a thank you"* (P9)

Collaborate: *"I think also it's been quite a lonely job because you are by yourself a lot of the time"* (P1)

The working environment and staff morale within the NHS were described as poor; *"It's just a horrible environment to work in"* (P8). Snow, 2002, argues that tackling work climate is the best way to retain more nurses within their jobs.¹⁷ She suggests addressing the six dimensions of organisational climate, as proposed by Litwin and Stringer.¹⁸ These include flexibility, responsibility, standards, rewards, clarity and team commitment.¹⁸ There are a lot of parallels between these criteria and the ten Cs, above. Notably, rewards (which could be as simple as verbal encouragement) were an important way to improve the work climate, and were identified by several F2s in the current study as lacking in the NHS.

The concept of *"non-handoverable job"* was interesting, and a possible reason for F2s staying later than their prescribed hours, and was potentially linked to them feeling undervalued. Taryn *et al.*

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3
4 (2013), conducted a grounded theory study to investigate reasons why residents in a Canadian
5 institution chose to stay after their shifts had ended. They found that the dominant rationalisation
6 was “*abiding by cultural norms*.”¹⁹ They also found that in a “*relay-team structure*”, residents were
7 likely to be able to “*pass the baton*” and go home, whereas when teams “*did not have the adequate*
8 *redundancy in manpower*”, there was a tacit obligation to stay.¹⁹ In the case of foundation doctors,
9 most handovers were given to a smaller Hospital At Night team, which may help to explain why
10 they felt that it was not possible to hand over all of the remaining jobs.

11
12 The F2s made some worrying statements about their fears of raising concerns and about being
13 penalised for doing so. They most often wanted to raise concerns about staffing levels, which is
14 one of the most common whistle-blowing situations.²⁰ It is acknowledged that whistle-blowing is
15 still often punished by the medical establishment, and the protection for whistle-blowers remains
16 inadequate.²⁰

17
18 Whilst the foundation programme is intended to consist of largely workplace-based learning,²¹ the
19 F2s in this study felt that it was important for them to have some formal teaching to support their
20 on-the-job training. Providing a specific study budget was one way in which the F2s understood
21 their training to be valued.

22
23 Most of the F2s did not have a mentor but would liked to have had one. Mentoring programmes
24 have been shown to improve job embeddedness.²² Research on medical students with mentors
25 showed that having a mentor gave a sense of security, gave hope for the future, increased
26 motivation and increased the feeling of belonging in a community.²³

27
28 Some of the F2s identified a lack of formal careers advice. This was important as one of the key
29 reasons for going abroad was not deciding on specialty choice, which might conceivably be
30 improved with better careers advice. This has previously been identified as a weakness of the
31 foundation programme.²¹

32 33 **The occupational perspective**

34
35 An increased salary abroad was seen as a “*nice bonus*”, but many of the F2s did not know what
36 their salary would be, and some were going to be working on a volunteer basis. In general, they
37 did not express a desire to go abroad for better pay, but did express a desire to be paid fairly for
38 the work they did.

39
40 The proposed changes to junior doctor contracts in England provoked mixed emotions amongst
41 the F2s. The changes were first proposed in July 2013, but negotiations stalled on multiple
42 occasions, with the result that junior doctors in England undertook industrial action in December
43 2015, March 2016 and April 2016. Further negotiations in May 2016 led to a proposed change in
44 the contract.¹⁰ These proposals made many of the Scottish F2s in this study wonder if they would
45 return to the UK, due to fears that the changes would affect Scottish contracts in the future, and
46 availability of specialty training jobs in Scotland due to competition from English trainees.

47
48 The F2s described the development of multiple transferable skills. This is important, because
49 development of such skills is associated with higher levels of job mobility.²⁴ In some ways, the
50 skills that they had developed had prepared them better for further foundation jobs, rather than
51 necessarily preparing them to enter specialty training. The transition to core medical training was
52 viewed as particularly daunting. The aim of the foundation programme is to “*bridge the gap*
53 *between undergraduate and specialty training*”,²¹ but to date there have been no studies to
54 evaluate how effectively it does this.
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Further study and research were cited as reasons for “*taking time out*”, as was having to choose a specialty at an early stage. The foundation programme evaluation identifies flexibility within the programme, as well as improved careers information and advice, as important recommendations for the future of the foundation programme.²¹

F2s often cited a desire to step off the “*treadmill*” or “*conveyor belt*” of training. They expressed a desire for individualised programmes, and viewed taking a “*year out*” as a way of providing an individual element for themselves. The foundation programme evaluation highlighted a “*lack of flexibility*” in the foundation programme, and a need to address this in the future.²¹

The foundation e-portfolio was viewed as a box-ticking exercise rather than as a useful opportunity to improve their skills. This concurs with previous research, which finds that foundation doctors consider the assessments to be “*excessive, onerous and not valued*”.²¹

The work group perspective

Loneliness at work, a lack of support from seniors, dysfunctional relationships and bullying at work were all cited as reasons for lack of enjoyment in their foundation jobs. These are reflected in the literature. For example, loneliness, reported by junior doctors in previous studies,²⁵ has been associated with depression.²⁶ The foundation programme evaluation (2011) describes a “*repeated theme of some trainees being asked to practise beyond their level of competence and without adequate levels of supervision.*”²¹ Furthermore, a questionnaire study of 594 junior doctors found that 37% reported being bullied in the previous year.²⁷ Most of the F2s reported having heard about a utopic Australasian system in which there are higher staffing levels, good support and a strong senior presence.

Bishop and Scott (1992) purport that task interdependence promotes stronger commitment to the organisation as a whole.²⁸ The structure of UK training prevents F2 doctors working interdependently with others. The structure of training is such that they must leave their current role at the end of the year, and as such they will never be leaving their current colleagues ‘in the lurch’. This may help to explain why none of the F2s expressed any guilt regarding leaving the NHS.

In keeping with previous research, the use of locums was associated with poor satisfaction at work.²⁹ However, rota gaps with no locum cover were associated with even greater levels of dissatisfaction in the current study.

The personal life perspective

The desire to seek a better work-life balance was frequently cited by the F2s as a reason to leave the UK. Some of the F2s also identified a negative impact of their work life on their health. Long numbers of consecutive days and nights worked have previously been shown to be associated with a poor work-life balance.³⁰

“Taking a break”

The overarching theme of “*taking a break*” is both surprising and heartening. It may represent a level of burnout in junior doctors, who are at once trying to take a break from the UK, from working, from the “*hum drum*”, from medical training, from being a doctor, from thinking about career progression and from the NHS. High levels of burnout have been reported previously, with between 40-76% of junior doctors estimated to have experienced burnout.³¹ It is heartening, however, that many of the F2s state a clear intention to return to the UK after “*taking a break*”, bringing with them new skills and experience from their time abroad.

Limitations

This study explores the in-depth views of Scotland-based F2 doctors regarding their training experience and their ideas about junior doctor jobs abroad. We have explored their explicit reasons for leaving, as well as some factors known to increase job mobility, in order to uncover some of the hidden reasons for junior doctors leaving the NHS. There have not been any other qualitative studies exploring this phenomenon. We have used a constructivist approach, and have therefore produced results which do not attempt to predict the future, but instead explore the intricacies of decision-making,³² and provide a springboard for further areas of research.

All of the participants were working as F2s in Scotland. This was deliberate: At the time of this research, there was a great deal of uncertainty surrounding proposed changes to junior doctor contracts in England.¹⁰ There was anger and frustration relating to the proposed changes,¹⁰ and we felt that interviews with English trainees were likely to be very focussed on junior doctor contracts, and lacking in some of the other rich data that we have uncovered. Unlike positivist research, these results cannot be claimed to be *generalisable*, but instead may be *transferable* to other contexts. For example, issues such as lack of careers advice or mentorship programmes may not apply to every area in the UK, or the world, but may apply to some. Although only F2s working in Scotland were interviewed, we aimed to obtain as diverse a range of views as possible, by interviewing F2s from all four regions, of different ages, a mix of genders, and with different specialty interests and destinations in mind. The age range of volunteers was narrow (24-27), and did not include any graduate entrants, despite our attempts to recruit as diversely as possible. This might feasibly be because older F2s may be less likely to consider leaving the NHS.

Junior doctors may have wanted to present a certain image of themselves to the researcher. We attempted to ameliorate this by using a non-threatening environment (participants were interviewed in their own homes via a video-link) and by ensuring anonymity. The researcher was also a doctor who had chosen to move abroad, thus reducing any threat of judgement towards participants.

Constructivism acknowledges that the researchers are biased. We do not try to minimise the bias, but instead reflect on the impact of the researchers' preconceptions on the data.³² Four of the researchers are doctors, three of whom work in the NHS and one who has moved abroad. We therefore carry our own experiences of working in the NHS environment, and feelings about moving away, which may add richness to the data. Many of the comments made by the F2s resonated with the report authors, and we were able to connect and relate to the F2s, especially when their experiences matched our own. We did not seek to simply support our pre-conceived views, but also to create new understanding about the driving forces behind F2s' decisions to leave.

Future research

This study has opened many avenues for possible future research. It would be interesting to follow the F2s into their new roles abroad, to find out if their expectations were met. It would be useful to explore their decision-making when deciding whether to return to the UK. The questions asked in this study could be posed from a more positivist perspective, perhaps by using this study as the basis for a questionnaire sent out to all F2s throughout the UK. We could consider conducting a similar study in other parts of the UK, to determine whether any of the results are transferable to other contexts. Finally, we could design, implement and evaluate a strategy, based on the results of this study, to encourage F2s to stay or come back to the UK.

Conclusions

For a variety of complex and individualised reasons, F2s are choosing to leave the UK after foundation training. Whilst some of their reasons might be amenable to changes in the UK, a great many of them may still choose to go abroad to experience a specific specialty, to explore the world, to pursue altruistic motivations, or simply to gain a completely new experience. Instead of focussing on trying to stop F2s from leaving, we should instead plan for them to leave, and make the UK healthcare system a desirable place for them to return to. We should also put in place plans to ease their transition back into UK medicine.

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Foundation Year 2 doctors' reasons for leaving UK medicine: an in-depth analysis of decision-making using semi-structured interviews

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19
20 Data sharing statement: Additional data is available by emailing sam.smith@ed.ac.uk

21 22 ABSTRACT

23
24 **Objectives:** To explore the reasons that doctors choose to leave UK medicine after their
25 foundation year two posts

26
27 **Setting:** All four regions of Scotland

28
29 **Participants:** Foundation year two doctors (F2s) working throughout Scotland who were
30 considering leaving UK medicine after foundation training, were recruited on a volunteer
31 basis. Maximum variation between participants was sought.

32
33 **Primary and secondary outcome measures:** Semi-structured interviews were coded
34 using template analysis. Six perspectives, described by Feldman and Ng, were used as the
35 initial coding template. The codes were then configured to form a framework that explores
36 the interplay of factors influencing F2 doctors' decisions to leave UK medicine.

37
38 **Results:** Seventeen participants were interviewed. Six perspectives were explored.
39 Structural influences (country- and world-wide issues) included visas, economic and political
40 considerations, structure of healthcare systems, and availability of junior doctor jobs
41 worldwide. Organisational influences (the NHS and other healthcare providers) included
42 staffing and compensation policies, the working environment and the learning environment.
43 Occupational influences (specific to being a junior doctor) comprised the junior doctor
44 contract, role and workload, pursuit of career interests and the structure of training. Work-
45 group influences (relationships with colleagues) included support at work, task
46 interdependence and use of locums. Personal life influences consisted of work-life balance,
47 and support in resolving work-life conflict. The underlying theme of "taking a break" recurred
48 through multiple narratives.

49
50 **Conclusions:** F2 give similar reasons to those given by any professional considering a
51 change in their job. However, working within the NHS as an F2 doctor brought specific
52 challenges, such as a need to make a choice of specialty within the F2 year, exposure to
53 workplace bullying and difficulties in raising concerns. Despite these challenges, most F2s
54 did not view their decision to leave as a permanent job change, but as a temporary break
55 from their current working lives.
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STRENGTHS AND LIMITATIONS

- This study explores the in-depth views of Scotland-based F2 doctors regarding their training experience and their ideas about junior doctor jobs abroad. It explores their explicit reasons for leaving, as well as some factors known to increase job mobility, in order to uncover some of the hidden reasons for junior doctors leaving UK medicine.
- This study fills a gap in the literature, as there have been few studies exploring the subject, and no previous qualitative studies examining this issue.
- A constructivist approach was used, and therefore the results do not attempt to predict the future, but instead explore the intricacies of decision-making, and provide a springboard for further areas of research.
- The F2s had a broad range of specialty interests, range of destination countries, country of origin, and both genders were represented. However, the age range was narrow and all F2 were based in Scotland. The results may therefore be transferable to other contexts but are not generalisable.
- While every attempt was made to put participants at ease, and create a non-threatening environment, the F2s may have wanted to present a certain image of themselves to the researcher, and may have chosen to hide some of their reasons for leaving accordingly.

INTRODUCTION

The Foundation Year 2 (F2) Career Destination Report 2016 showed that only 50.4% of UK F2 doctors progressed to UK specialty training, a year-on-year decrease from 71.3% in 2011, 67.0% in 2012, 64.4% in 2013, 58.5% in 2014, and 52.0% in 2015.¹ Between 2010 and 2013 the numbers of UK doctors applying for a General Medical Council (GMC) certificate of good standing, enabling them to work abroad, increased by over 16% from 4080 to 4741.² The F2 Career Destination Report provides further evidence that many of these applicants are F2 doctors: in 2015, 10.8% had secured or intended to secure employment as a doctor outside the UK.¹

As F2 doctors move abroad, take career breaks or leave the profession altogether, UK medicine is left in a state of crisis, with 12% of GP specialty training posts unfilled in 2014³ and 17% of Scottish GP practices reporting at least one vacancy.⁴ The Scottish Government have recently announced that there will be 100 new GP training places this year,⁵ but given the large numbers of F2s leaving the UK, it may not be possible to fill these places. The detrimental effect of the exodus might be mitigated to some extent if many of the doctors who leave after foundation training subsequently return to UK medicine. However, evidence suggests this is often not the case: a questionnaire study of UK doctors who had settled permanently in New Zealand showed that only 30% had originally intended to stay long term, suggesting that despite the majority of doctors having intentions to return to the UK when they initially move abroad, many do not do so.⁶

There is a surprising lack of research into the reasons why doctors decide to leave UK medicine. Two studies have attempted to gain such insights using questionnaires. Moss *et al.* sent a postal questionnaire to a group of UK graduates in 1999, approximately a year after graduation.⁷ Of the 4221 graduates, 2727 responded. Sixteen percent of respondents indicated that they were probably or definitely not going to continue to practice medicine in the UK. The main reasons cited included working conditions and lifestyle factors.⁷ Sharma *et al.* sent a questionnaire to UK doctors who had settled in New Zealand in 2012.⁶ Out of 419 doctors sent the questionnaire, 282 responded. The majority of respondents (69%) stated that their reason for moving was for a clinical job.⁶ Other reasons included seeking other work, for a holiday, to spend time with family or friends, better lifestyle in New Zealand,

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4 or disillusioned with the NHS or with life in the UK. Thus, the reasons for moving abroad
5 were similar to those found in 1999, relating to perceived poorer working conditions in the
6 UK and perceived improved lifestyle abroad.

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8 These studies were carried out prior to the sharp increase in the proportion of F2 doctors
9 opting to leave UK training. It is therefore timely to re-examine this significant and growing
10 issue, to understand more fully the reasons underlying the increased numbers of F2 doctors
11 leaving UK medicine. Furthermore, there have not been any qualitative studies which have
12 aimed to characterise the reasons for F2 doctors leaving UK medicine (beyond the short
13 generic stems used in questionnaire-based studies), or which have investigated the relative
14 influences of the salient factors on doctors' decisions to leave.

15 16 **Research Aims**

17
18 The aim of this interview study was to explore F2 doctors' reasons for leaving UK medicine,
19 in order to better understand how they might be encouraged to stay.

20 21 **METHODS**

22 23 **Philosophical assumptions**

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25 This research required a constructivist approach, in order to explore in detail the decision-
26 making processes of F2 doctors. As per Guba and Lincoln's description of the metaphysical
27 paradigms, the following philosophical assumptions were made: 1. The ontology is relativist
28 (there is no objective reality) 2. The epistemology is transactional and subjectivist (truth is
29 constructed by the researchers through interactions with the world) 3. The methodology is
30 interpretative and explanatory, rather than experimental.⁸ The result of this research will *not*
31 be a definitive explanation of why F2 doctors leave UK medicine, but will instead be an
32 exploration of the myriad of factors influencing decision-making.

33 34 **Framework**

35
36 While there have been limited studies examining the reasons that F2 doctors choose to
37 leave UK medicine, there has been research examining "*career mobility*" versus "*career*
38 *embeddedness*" in professionals in general.⁹ Feldman and Ng (2007) examined the
39 pertinent literature and assimilated it into six perspectives that influence career mobility
40 versus embeddedness. In brief, these perspectives were as follows:

- 41 1. The structural perspective: Macroeconomic factors and social and legal factors, for
42 example, the number and quality of jobs available. UK-wide or worldwide factors
43 which are not specific to a single profession.
- 44 2. The organisational perspective: Organisational staffing and compensation policies.
45 Any organisational policy that affects all the workers within that organisation.
- 46 3. The occupational perspective: Salary and workload. Organisational policies which
47 affect a specific occupational group.
- 48 4. The work group perspective: Social connections and interactions that professionals
49 have, both within their own organisation and between different organisations.
- 50 5. The personal life perspective: The impact that the non-work part of a professional's
51 life has on their decision to move (such as friends and family). Includes work-life
52 balance, and how the impact of work on personal life influences an individual's
53 decision-making.
- 54 6. The personality perspective: The impact of personality types such as the "big five" or
55 attachment styles on career mobility versus embeddedness.⁹

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Feldman and Ng's six perspectives represent an appropriate starting point for this study, because the factors above resonate with both the authors' experiences within medicine and the previous research detailed above.^{6,7}

A pictorial representation of the six perspectives is shown in figure 1.

Ethical approval

The need for full ethical approval was waived by the research ethics committees in South East Scotland, East of Scotland, North of Scotland and West of Scotland.

Data collection

Participant recruitment

At the time of this research, there were contentious proposed changes to junior doctor contracts in England resulting in strike action by junior doctors.¹⁰ These recently-proposed contractual changes would inevitably have been the focus of conversation had the study recruited doctors currently working in England. For these reasons, this study focussed on F2 doctors currently working in Scotland.

Doctors who planned to leave UK medicine on completion of foundation training were recruited on a volunteer basis. Participants were invited via a notice in the Scotland-wide Foundation bulletin, a message in the Foundation trainee e-portfolio, a notice in the BMA Scotland junior doctors committee newsletter, opportunistically in the workplace and at medical education conferences, using social media and through snow-ball sampling.¹¹ Volunteers who showed interest in participating were sent information about the study and then decided whether or not to participate. Those who did participate completed consent forms.

Maximum variation was sought, with the aim of including participants from all Scottish deaneries, both genders, a variety of proposed destinations, a variety of nationalities, a variety of career interests and as broad an age range as possible. Whilst acknowledging that saturation is always a "matter of degree",¹² data collection ceased when the new data generated did not add to the overall framework.

Semi-structured interviews

A single researcher (SS) conducted online-video semi-structured interviews with participants, to explore their reasons for leaving UK medicine. The researcher is a female GP with a medical education doctorate, with experience of qualitative research interviewing both during her doctorate and subsequently. Prior to interview commencement, participants were informed of the researchers' background, purpose of the research, and were invited to ask any questions.

The interview structure was based on the factors identified by Feldman and Ng.⁹ During the interviews, particular attention was paid to eliciting rich descriptions of the decision-making process including the factors involved and the ways in which salient factors were identified and assimilated. Data analysis was carried out in tandem with collection, in order that new themes could be expanded and explored in subsequent interviews. Interviews were audio recorded, transcribed verbatim and anonymised. Field notes were taken during interviews when required. Participants received a £20 Amazon voucher as recompense for their time.

Ethical considerations

Data storage: Participant names were only used when absolutely essential (e.g. on consent forms), and were not used to identify files or recordings. All data, including audio-recordings and transcriptions were de-identified and stored in a separate location from any identifiable data on a secure, password-protected computer. Audio files were deleted once transcription was complete and individuals were assured of total anonymity.

Impact on individuals: Participants were reminded at the start of the interview that they may terminate the interview and withdraw from the study at any point without penalty. The main researcher (SS) has significant experience in various interview-based techniques. In addition, through her GP training, she has learnt to identify emotional cues and non-verbal manifestations of distress. We recognised that some participants might find discussions regarding their future or the prospect of leaving medicine confronting and upsetting. Appropriate support was offered to any doctors who become distressed during data collection and during debrief they were provided details of external sources of support. The team ensured the interviewer was not in a position of power over any participant, for example as an educational or research supervisor.

Data analysis

Initial data analysis was undertaken by SS using template analysis.¹³ In template analysis, the codes are generated both 'a priori' and inductively, during the analysis.¹³ The framework provided by Feldman and Ng's literature search⁹ was used for the initial template, but this was later modified and amplified by the data. Data were coded in Microsoft Word by SS then reviewed by one of three additional researchers, to check for other interesting codes and themes that may not otherwise have been identified. The codes were renamed, reshuffled and redefined to ensure resonance with the data and overall coherency. The codes were then configured to form a framework that explores the interplay of factors influencing F2 doctors' decisions to leave UK medicine.

RESULTS

Participants

Nineteen interviews were scheduled and 17 took place (two participants failed to respond after initially showing interest). Of the 17 participants, 12 were women and five were men. Six were from the South East region, five from the East, three from the North and three from the West. Five planned to go to Africa (South Sudan, Uganda, South Africa), 11 planned to go to Australia or New Zealand and one planned to go to Europe (Germany). Eight planned to ultimately apply for medical specialties, three to surgery, one to psychiatry, two to obstetrics and gynaecology and three were undecided. Eight were Scottish, three were English, one was Northern Irish, one was Welsh, one was from Africa, one from Singapore, one from Malaysia and one from Hong Kong. All participants were aged 24-27 and all had studied medicine in the UK.

Interviews

All interviews were conducted online with video (FaceTime or Skype). Participants were interviewed in their own homes. Only the interviewer and participant were present. Interviews lasted, on average, 42 minutes (28 to 65 minutes). Repeat interviews were not required.

Coding framework

The resultant coding framework is explained below. The personality perspective is not included in this paper, as it is not amenable to intervention. Any themes deemed not amenable to intervention (for example, climate, influence of friends and family or personal interests) are also excluded from this analysis. Themes that discouraged doctors from visiting certain countries (for example, needing extra exams or concerns about personal safety) were also not included in this analysis.

Structural perspective

Visas: F2s reported that Australia and New Zealand made it relatively easy for them to navigate the process of obtaining a visa. However, F2s who were non-UK citizens reported that UK visa made it more difficult for them to stay in the UK:

“...if I wanted to do that [locum for six months in the UK], I couldn't, I need an actual job that I'm doing for the whole year to be able to stay.” (P12 – a non-UK citizen)

Economic and political considerations: At the time of this research, Scotland was holding a referendum regarding whether it should become independent of the United Kingdom. Financial uncertainty brought about by the Scottish independence referendum was cited as a reason to move abroad now. Some participants stated that if Scotland were to become independent, this might put them off returning to the UK.

“If things stayed as they are just now, I would come back quite easily. But, if Scotland was to become independent that would be a trickier one. Where are they going to get the money from to fund the budget? ... So, if that was to happen then it would be a bit more difficult to come back.” (P3)

During the course of the research, the UK also held a referendum regarding its independence from the European Union. The UK's exit from the EU was seen as a potential future barrier to working in EU countries, but did not influence the decision to go now.

“I was shocked, to see the news [about the UK's decision to leave the EU]. But I guess it won't happen for another two years, at least. And hopefully that wouldn't affect my chance of finding a job, because I'm going now, instead of in two years. Where I think for people after me, then it might not be as easy actually, to find a job abroad, especially in Europe.” (P14)

The full list of subthemes explored within the structural perspective are showed in table 1. In table 1 and the subsequent tables, many of the subthemes directly correlate with the Feldman and Ng framework. Those that are loosely correlated are denoted with one asterisk, and those which are not correlated are denoted with two stars.

Table 1: Structural perspective

Subtheme	Details	Illustrative quote
<i>Moving to another country in general</i>		
Visas*	F2s reported that Australia and New Zealand made it relatively easy for them to navigate the process. UK visa rules were cited as a reason for non-UK citizens leaving the UK	"...if I wanted to do that [locum for six months in the UK], I couldn't, I need an actual job that I'm doing for the whole year to be able to stay." (P12 – a non-UK citizen)
Economic and political considerations	<p>The Scottish independence referendum Financial uncertainty brought about by the recent Scottish independence referendum was cited as a reason to move abroad now. Some participants stated that if Scotland were to become independent, this might put them off returning to the UK</p> <p>Britain's exit from the EU Britain's exit from the EU was seen as a potential future barrier to working in EU countries, but did not influence the decision to go now</p>	<p>"If things stayed as they are just now, I would come back quite easily. But, if Scotland was to become independent that would be a trickier one. Where are they going to get the money from to fund the budget? ... So, if that was to happen then it would be a bit more difficult to come back." (P3)</p> <p>"I was shocked, to see the news [about the UK's decision to leave the EU]. But I guess it won't happen for another two years, at least. And hopefully that wouldn't affect my chance of finding a job, because I'm going now, instead of in two years. Where I think for people after me, then it might not be as easy actually, to find a job abroad, especially in Europe." (P14)</p>
<i>Moving to another country as a doctor</i>		
Structure of healthcare systems*	Certain healthcare systems, such as Malaysia, Singapore, Canada and the United States, were seen as undesirable to work in. Reasons included long working hours, poor training opportunities, rural placements and health inequality. Some F2s felt that different healthcare systems helped the public to value healthcare professionals more	<p>"I suppose medics are viewed in a better way [in Australia], just more respect. The patients probably pay a bit of insurance and they do have to take accountability for their own health care and that way they do then value all the healthcare professionals more, not just the medics." (P6)</p> <p>"Frankly, I didn't want to work the 100 hour weeks that they do in Singapore." (P10)</p>
Availability and quality of junior doctor jobs in the world	Many of the F2s had found it relatively easy to get the job of their choice, and quantity of jobs in their destination country was not seen as an issue. Some F2s felt that the quality of available jobs in their destination country was low, but this was not a big concern, as their reasons for leaving were not necessarily to seek quality training opportunities	"My impression is that basically you end up with the jobs that no-one else wants from Australia or New Zealand. Quality-wise you're probably ending up in a job that is less good than you would get in the UK but as a friend of mine put it to me you're not going there really for the clinical exposure... most people are going there because they want a different experience." (P1)
Type of patients and medicine encountered**	The typical NHS patient was viewed by some as a "chronic disease patient", with many climate and lifestyle related conditions. Going abroad was, for some, a way of experiencing different types of medicine	"I'm really hoping that I get a snake bite, just because that'll be the moment that I've made it in Australia. I know there's quite interesting cultural issues to medical problems. So the Aboriginal population has a huge alcohol problem... And they have different problem drugs, to here as well, so like, crystal meth. Stuff like that will be really fascinating to learn about." (P15)

Organisational perspective

Feeling valued: Many of the F2s believed that Australian and New Zealand healthcare organisations valued their staff more highly than the NHS does.

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6 *"How often have you stayed overtime and got no...no one thanks you for it. You get upset because you're hungry, tired, haven't gone to the*
7 *toilet and you're never getting paid for it." (P10)*
8

9 *Working environment:* The working environment and staff morale within the NHS were described as poor.

10
11 *"There's just a lot of kind of negativity in the NHS at the moment amongst junior doctors and I don't know if it's become a bit of a culture thing*
12 *as well... We have great resources, a great structure, but something at the moment isn't working. We don't have enough money or we don't*
13 *have enough doctors and it's just a horrible environment to work in I think." (P8)*
14

15 In contrast, F2s imagined that the working environment in Australia and New Zealand were more pleasant.

16
17 *"The Australian people's personalities are very relaxed and very chilled, so a lot of people have said that that it's a nice environment to work*
18 *in. In that sense I think it could differ between that and the UK." (P11)*
19

20 *Non-handoverable jobs:* F2s described staying late at work for jobs that were "non-handoverable". These were jobs that were not urgent but they did
21 not feel they could hand over to the next shift.

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23 *"It's things like ordering bloods for tomorrow. Things you know that should have been done during the day. But sometimes, you're just so*
24 *busy, it doesn't get done.." (P10)*
25

26 *Raising concerns:* F2s were unsure about how to raise concerns and were worried that they might be penalised for doing so.

27
28 *"How are you supposed to give any of this feedback to the top people, because where on earth are they? I think also sometimes you're*
29 *worried if you had a concern and you expressed it, that number one, it would fall on deaf ears, and also would you be getting into trouble for*
30 *expressing concerns?" (P9)*
31

32 *Formal teaching:* Australia had a reputation for providing more formal teaching than that which is offered in the UK.

33
34 *"One of my friends who is working out in Perth [Australia], has said actually she has like hourly sessions kind of every other week where she'll*
35 *get bedside teaching. That's way above and beyond what I've had. I don't think I've had bedside teaching beyond what happens on a ward*
36 *round." (P13)*
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38 *Mentorship:* Most of the F2s did not have a mentor but would liked to have had one.
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“My consultant [in a previous job] was very good in encouraging and looking at options and she was probably the person who gave me the most advice about careers. I found that immensely useful, so I think to have some kind of continuity with someone who could be a mentor would have been probably very helpful. (P8)

Careers advice: Some F2s stated that they had received little or no careers advice

“I think most of the time people expect you to just figure out on our own what you want to do and get the advice that you want on your own.” (P12)

Further examples are given in table 2.

Table 2: Organisational perspective

Subtheme	Details	Illustrative quote
Staffing and compensation policies		
Location of jobs**	Current staffing policies result in F2s not necessarily working in the region of the UK in which they would prefer to live	“As much as I love being here, I feel it is not a very attractive region within the UK. It's probably the bottom of the pile.” (P6)
Rota gaps**	Most of the F2s had worked in jobs in which there were rota gaps, and most had been asked to increase their hours to fill these gaps	“All my previous rotas, they've never been fully staffed... we were three down at one point, and we just had to cover the bulk of that. And we sent emails saying, this is so unsafe, but you don't really get very far with that.” (P4)
Rota policies**	In Australia, it was possible to pair rotas with a partner	“One perk of Australia, the pairing, or more consideration to the rota. They're not fully linking mine, but they're going to match when we're working weekends.” (P15)
Perks	Australian organisations were thought to have good perks compared with the NHS, which contributed to the sense of feeling valued. Having somewhere to go during breaks, such as a doctors' mess was felt to be important	“It's kind of hard to take a break and dissociate yourself from work when there's nowhere to go.” (P2)
Working environment		
Feeling valued	Many of the F2s felt that Australian and New Zealand organisations valued their staff more than the NHS did	“How often have you stayed overtime and got no...no one thanks you for it. You get upset because you're hungry, tired, haven't gone to the toilet and you're never getting paid for it.” (P10)
“Non-handoverable jobs”**	F2s described staying late at work for jobs that were “non-handoverable”. These were jobs that were not urgent but they did not feel they could hand over to the next shift	“It's things like ordering bloods for tomorrow. Things you know that should have been done during the day. But sometimes, you're just so busy, it doesn't get done..” (P10)
Working atmosphere	The working atmosphere within the NHS was felt to be very negative. The working atmosphere in Australia was thought to be more relaxed than in the UK	“The Australian people's personalities are very relaxed and very chilled, so a lot of people have said that that it's a nice environment to work in. In that sense I think it could differ between that and the UK.” (P11)

Raising concerns**	F2s were unsure about how to raise concerns and were worried that they might be penalised for doing so	<i>"How are you supposed to give any of this feedback to the top people, because where on earth are they? I think also sometimes you're worried if you had a concern and you expressed it, that number one, it would fall on deaf ears, and also would you be getting into trouble for expressing concerns?" (P9)</i>
Learning environment		
Learning on the job**	F2s enjoyed being challenged, and this was viewed as a positive part of the learning process. Going abroad was viewed by the F2s as good for on the job training	<i>"You can tell people who have been away, and have come back. Just, they're much more confident, they've got much more experience." (P4)</i>
Formal teaching**	Australia had a reputation for providing more formal teaching than that which is offered in the UK	<i>"One of my friends who is working out in Perth [Australia], has said actually she has like hourly sessions kind of every other week where she'll get bedside teaching. That's way above and beyond what I've had. I don't think I've had bedside teaching beyond what happens on a ward round." (P13)</i>
Mentorship**	Most of the F2s would have liked to have a mentor, had that been available to them	<i>"My consultant [in a previous job] was very good in encouraging and looking at options and she was probably the person who gave me the most advice about careers. I found that immensely useful, so I think to have some kind of continuity with someone who could be a mentor would have been probably very helpful. (P8)</i>
Careers advice**	Some F2s stated that they had received little or no careers advice. Others were satisfied with the careers advice that they had been given	<i>"I think most of the time people expect you to just figure out on our own what you want to do and get the advice that you want on your own." (P12)</i>
Balance of service provision versus learning**	Some of the F2s felt that there was a greater emphasis on service provision than on training	<i>"When I was in gen med, there could have been opportunities to observe lumbar punctures, do more pleural taps and things. But we just had to do so many discharge letters and referral forms. And I mean, it just wasn't helpful for our training." (P10)</i>

Occupational perspective

Salary: An increased salary abroad was seen as a *"nice bonus"*, but many of the F2s did not know what their salary would be, and some were going to be working on a volunteer basis. In general, they did not express a desire to go abroad for better pay, but did express a desire to be paid fairly for the work they did.

Junior doctor contracts: The proposed changes to junior doctor contracts in England provoked mixed emotions amongst the F2s.

"I think if I worked down there [in England] I'd be totally disheartened and wouldn't really want to continue. Sometimes I think I probably wouldn't want to do this job if I was paid any less... And it'll definitely change my perception if I come back and Scotland's gone the same way, what will I do?" (P2)

"I always wanted to work in London, so if I was applying for CMT1, I would have liked to have apply down South. [But] there was a lot of uncertainty and there's still a lot of uncertainty now about what the contracts are going to be like. I think they have started releasing the

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6 *provisional contracts now and they look terrible. You've been paid less and you're working a lot more and you're working one in two*
7 *weekends. It didn't seem like a good thing to trade rather than working somewhere where there is a good work life balance and sunshine and*
8 *people appreciate what you do for a living in Australia - why would I want to move to England?" (P12)*
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11 Transferability of skills: F2s described the development of transferable skills which would help them in their future jobs

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13 *"I find now I'm less afraid of difficult conversations with families or patients. You have to be better at prioritisation and organising your time.*
14 *Also trying to delegate to other people and knowing when it's appropriate to call for senior help." (P1)*
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16 However, some F2s did not feel that their skill development had adequately prepared them to enter specialty training directly

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18 *"When I see people go and start their CMT [core medical training], they cover CCU [the coronary care unit] and renal on their nightshift. It's*
19 *funny because at the moment I'm the one calling them about this abnormal ECG [electrocardiogram], but then you think, God, in four months'*
20 *time I'm the one who is getting called... that sounds awful. I think maybe I am just not quite ready to go into CMT yet." (P9)*
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22 *Further study and research:* Some of the F2s planned to spend part of their time after F2 completing further study or research.

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24 *"I am spending the first three months doing a tropical medicine diploma..." (P5)*
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26 Travel was also seen as a potential way of building relationships for future research collaborations

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28 *"I think it would probably be good for your career to have a wider experience, wider contacts, certainly academically bigger scope for*
29 *collaboration." (P16)*
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31 *Conveyor belt or treadmill of training:* Some of the F2s described feeling like they were on a "conveyor belt" or "treadmill" of training, and felt that post-
32 F2 was a good opportunity to step off for a while.

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34 *"You are on this conveyor belt, you're 17 and then you've signed up for life. I think, for me, it was just the last couple of years, you realise*
35 *what you've actually committed to. If I commit to a training programme, that's six years or so and after that you are looking at trying to get*
36 *consultancy posts quite quickly. I would think on that kind of timescale you are thinking about family and mortgages... I don't think you can*
37 *really travel. This is an opportunity to go away for so long whilst still maintaining your clinical practice." (P6)*
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39 *E-portfolio:* The F2s felt that the e-portfolio was cumbersome to complete and "too vague to be useful".
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"If I can just not have to deal with any portfolio for two years I will be delighted. I think it just detracts so much from any enjoyment that you have... especially with the foundation e-portfolio because they have to design it so generically that some things that they want you to do can be incredibly difficult depending on the particular combination of jobs that you have" (P17)

Further examples of subthemes within the occupational perspective are given in table 3.

Table 3: Occupational perspective

Subtheme	Details	Illustrative quote
The junior doctor contract, role and workload		
Salary	Salary was unimportant to many of the F2s, to the extent that some did not even know how much they would be paid in their future roles. Others were hoping to have a higher salary, with opportunities for saving money. For many, a higher salary was a "nice bonus" rather than a reason for going	<i>"I would say it's an added bonus, I would say if they were going to say you will get paid the same as you are just now, I would still go."</i> (P3)
Proposed changes to contracts in England**	The proposed changes to junior doctor contracts in England had unsettled the F2s. They had mixed feelings about going away during a time of uncertainty, and concerns about what it might mean for them if they chose to return to the UK One of the F2s had considered applying to specialty training in England, but had decided instead to apply to Australia, partly as a result of the proposed changes to junior doctor contracts in England	<i>"I think if I worked down there [in England] I'd be totally disheartened and wouldn't really want to continue. Sometimes I think I probably wouldn't want to do this job if I was paid any less... And it'll definitely change my perception if I come back and Scotland's gone the same way, what will I do?"</i> (P2) <i>"I always wanted to work in London, so if I was applying for CMT1, I would have liked to have apply down South. [But] there was a lot of uncertainty and there's still a lot of uncertainty now about what the contracts are going to be like. I think they have started releasing the provisional contracts now and they look terrible. You've been paid less and you're working a lot more and you're working one in two weekends. It didn't seem like a good thing to trade rather than working somewhere where there is a good work life balance and sunshine and people appreciate what you do for a living in Australia - why would I want to move to England?"</i> (P12)
Labour intensity	In general, labour intensity was felt to be high in F2 posts, which was exacerbated by understaffing F2s had heard that the labour intensity in Australia and New Zealand was lower	<i>"We have a lot of staff shortages. Usually there's only one of us on the ward. You feel like you're fighting fires a lot of the time."</i> (P1) <i>"From what I hear it's meant to be slightly less intense particularly in A&E, as I read a few articles. People definitely say you are less stressed because you've just got more people on the shop floor."</i> (P1)
Junior doctor skills		
Transferability of skills	F2s described the development of transferable skills which would help them in their future jobs Some F2s did not feel adequately prepared to enter specialty training directly	<i>"I find now I'm less afraid of difficult conversations with families or patients. You have to be better at prioritisation and organising your time. Also trying to delegate to other people and knowing when it's appropriate to call for senior help."</i> (P1) <i>"When I see people go and start their CMT [core medical training], they cover CCU [the coronary care unit] and renal on their nightshift. It's funny because at the moment I'm the one calling them about this abnormal ECG [electrocardiogram], but then you think, God, in four months' time I'm the one who is getting called... that sounds awful. I think maybe I am just not quite ready to go into CMT yet."</i> (P9)

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Pursuit of career interests		
Specific clinical job**	Some F2s were going away for a specific clinical job, which they could not do in the UK	<i>"I only wanted to go to New Zealand if I was going to get a particular job in a particular department... I've got a registrar job as a haematologist out there... If I stayed here in the UK I would have had to just apply for CMT, and because haematology is a bit more of an unusual speciality, quite a lot of CMT trainees don't even get to do any haematology, and I would only get to do four months of it anyway."</i> (P9)
Further study and research**	Some of the F2s planned to spend part of their time after F2 completing further study or research	<i>"I am spending the first three months doing a tropical medicine diploma..."</i> (P5)
	Travel was seen as a potential way of building relationships for future research collaborations	<i>"I think it would probably be good for your career to have a wider experience, wider contacts, certainly academically bigger scope for collaboration."</i> (P16)
Structure of training		
Rigidity of training structure**	Some of the F2s would like to have completed one year abroad, but planned to complete two years due to the inconsistencies between the British and Australasian year turnover	<i>"The Australian medical year starts in January whereas the British one starts in August it does mean that if you end up with say a 12 month job starting in January it would be difficult to come back within one year. So, one year may be two."</i> (P1)
	F2s who wanted to enter specialties with long run-through programmes were motivated to spend time away after F2, as it may be their last chance in a number of years	<i>"I want to do obstetrics and gynaecology. It's run through for eight years, so it's a long commitment and there will be no opportunity to go abroad at all during that. We'll be contract free from August, so we can actually go away. It's basically the only time."</i> (P7)
Deferred entry schemes**	Many of the F2s would have considered applying for deferred entry schemes, had they been available	<i>"I would have applied for CMT and GP and, you know, that would have meant that, A, it would be nice to know that you've got that certainty of having a job at the end of the year and, B, it would mean not having to come home at Christmas time for applications."</i> (P8)
Choosing a specialty**	Some of the F2s stated that their main reason for going abroad was that they had not decided which specialty they wished to apply for, or were not yet certain.	<i>"Part of the reason why I'm taking a year out is I couldn't decide between different specialities... I'm really buying myself a bit more time."</i> (P1)
	One F2 would like to have applied for a "broad based training" scheme, rather than decide on a specialty at this stage	<i>"The broad based training that they had down South, it was never introduced in Scotland, but that had paediatrics, GP, medicine and stuff in it, and I considered that for a while, just to delay the decision-making process."</i> (P5)
	One F2 felt that she had decided too late on her specialty application, and wanted more time to appropriately build her CV	<i>"I maybe know what I want to do in the long-term but need to be more set on it. I had done my interview ages ago, and I wasn't even ready for that at all. My CV wasn't built up well enough either, I needed the extra few months to do it. And I'll try and use the next two years to do that as well."</i> (P2)
Conveyor belt / treadmill of training**	Some of the F2s described feeling like they were on a "conveyor belt" or "treadmill" of training, and felt that post-F2 was a good opportunity to step off for a while	<i>"You are on this conveyor belt, you're 17 and then you've signed up for life. I think, for me, it was just the last couple of years, you realise what you've actually committed to. If I commit to a training programme, that's six years or so and after that you are looking at trying to get consultancy posts quite quickly. I would think on that kind of timescale you are thinking about family and mortgages... I don't think you can really travel. This is an opportunity to go away for so long whilst still maintaining your clinical practice."</i> (P6)
E-portfolio and WPBAs**	The F2s felt that the e-portfolio was cumbersome to complete and too vague to be useful	<i>"If I can just not have to deal with any portfolio for two years I will be delighted. I think it just detracts so much from any enjoyment that you have... especially with the foundation e-portfolio because they have to design it so generically that some things that they want you to do can be incredibly difficult depending on the particular combination of jobs that you have"</i> (P17)
Four-month rotations**	One of the F2s described a dislike of short rotations and a desire to stay in one place for a longer period of time	<i>"I'm fed up of changing jobs every four months. I'm doing obs and gynae at the moment and I'm really enjoying it but it took me three months to start to feel like I was comfortable dealing with all the obstetric stuff and getting into the groove of going to theatre, and then I'm changing in less than a month..."</i> (P17)

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The need to reapply and threat of relocation**	One of the F2s described a dislike of the UK system in which it is necessary to reapply for jobs every two years, with a threat of relocation to another area of the UK	<i>"I actually think that I'm quite a scared person, and I don't like changes. Even if you get into an ST1, you would have to compete again to get an ST3 position. What if you have to move across the country? It's just so unstable, the life in Britain, I'd rather compete once, and get a job, and you're just allowed to stay there for five years."</i> (P14)
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Work-group perspective

Support at work: Other junior doctors were viewed as the most important social relationships at work. Loneliness at work, in particular a lack of contact with other junior doctors, affected their enjoyment at work.

"I think also it's been quite a lonely job because you are by yourself a lot of the time. We don't have F1's. We don't have registrars. I didn't realise how much that can affect your job satisfaction... ..because thinking back all the other jobs I've had have been in really big teams and perhaps even when we were busy and it was maybe a bit stressful you could moan about it to somebody else and the loneliness affects you I think..." (P1)

Lack of support from seniors was reported in a number of Foundation jobs, and affected the F2' enjoyment at work.

"In neurosurgery the registrars weren't very... they're not a very supportive bunch. There's someone suddenly blowing a pupil and you're like, is this person dying? What am I going to do? They'd be like, 'I'm busy, sort it'." (P3)

Bullying from senior doctors was an issue for some of the F2.

"I was sitting flicking through a massive set of notes and then the consultant walks round the corner and goes; 'What are you doing?' and shouts at me in front of all the nurses, everyone on the ward. Then when you get a bit tearful tells you to grow up in front of everyone, very publically. Numerous occasions like that, particularly in surgical jobs. Just being made to feel that you're never good enough and never getting any thanks for what you do. I don't know for sure that that's different in Australia, but from all the feedback I've got from everyone that's in Australia and New Zealand working at the minute it appears to be quite a bit different." (P2)

Task interdependence: F2s did not worry that their leaving would impact on their colleagues, and felt that in some ways it may advantage F2s who chose to stay

"If you look at people leaving as a whole it will make the jobs easier to get in some ways because they'll have less competition. It's different if you're leaving a rota, if you're already in a training position, but it shouldn't affect my colleagues because I've no obligation to be there in that hospital." (P7)

They felt that their going away on a “gap year” had a small effect when compared with the “underlying problem of not enough people”

“I maybe haven't thought about it but I'm contributing to that gap... whilst I very much am aware that I am trying to justify it's okay for me to go away and I'm not going to screw everybody over...for next year, I think that the underlying problem is there just not enough people. I think people taking a break is... relatively negligible to the fact that there just aren't enough bodies...” (P6)

Working with locums; Working with locums was generally viewed unfavourably.

“Sometimes you can get people that are completely new to the specialty and healthcare around the UK or even healthcare at all and that can be more challenging. They're at my level and they're filling up a gap in my rota slot at my level but at the same time I find them depending on me...which can be a bit difficult.” (P16)

Additional examples of the ways in which the work-group perspective influenced their decision-making are given in table 4.

Table 4: Work-group perspective

Subtheme	Details	Illustrative quote
Support at work	Other junior doctors were viewed as the most important social relationships at work	<i>“You're working with the same big bunch of people. So, you get to know quite a lot of people. It was a really good sized job actually for me, for making friends and creating like a social circle. I actually did quite enjoy it.” (P13)</i>
	Loneliness at work, in particular a lack of contact with other junior doctors, affected their enjoyment at work	<i>“I think also it's been quite a lonely job because you are by yourself a lot of the time. We don't have F1's. We don't have registrars. I didn't realise how much that can affect your job satisfaction... ..because thinking back all the other jobs I've had have been in really big teams and perhaps even when we were busy and it was maybe a bit stressful you could moan about it to somebody else and the loneliness affects you I think...” (P1)</i>
	Lack of support from seniors affected their enjoyment at work	<i>“In neurosurgery the registrars weren't very... they're not a very supportive bunch. There's someone suddenly blowing a pupil and you're like, is this person dying? What am I going to do? They'd be like, 'I'm busy, sort it!'.” (P3)</i>
	Bullying from senior doctors was an issue for some	<i>“I was sitting flicking through a massive set of notes and then the consultant walks round the corner and goes; 'What are you doing?' and shouts at me in front of all the nurses, everyone on the ward. Then when you get a bit tearful tells you to grow up in front of everyone, very publically. Numerous occasions like that, particularly in surgical jobs. Just being made to feel that you're never good enough and never getting any thanks for what you do. I don't know for sure that that's different in Australia, but from all the feedback I've got from everyone that's in Australia and New Zealand working at the minute it appears to be quite a bit different.” (P2)</i>
	Lack of support was not universal. Some of the F2s experienced good senior support at work	<i>“From a service provision point of view, I felt very well supported. I've always had seniors around to ask for help, even on my surgical jobs...” (P13)</i>
	Many F2s had heard that there was good support from senior staff in Australia and New Zealand	<i>“From what I've heard it is very consultant heavy... I don't think I'll be left as alone as I am here. I think if I'm on call, there will always be a registrar around, and again there will be juniors below me.” (P3)</i>

	Poor relationships with the nursing staff affected enjoyment at work in at least one case	<i>"The nursing staff wouldn't listen to me. They would then go and get consultants and run everything I did past them. There are some strong characters in that department and it's well known that that is the case. I just clashed with them and I find it quite condescending and made me feel like, that you weren't a doctor, that you are more a medical student because everything you said had to be verified by a consultant."</i> (P9)
Task interdependence	F2s did not worry that their leaving would impact on their colleagues, and felt that in some ways it may advantage F2s who chose to stay They felt that their going away on a "gap year" had a small effect when compared with the "underlying problem of not enough people"	<i>"If you look at people leaving as a whole it will make the jobs easier to get in some ways because they'll have less competition. It's different if you're leaving a rota, if you're already in a training position, but it shouldn't affect my colleagues because I've no obligation to be there in that hospital."</i> (P7) <i>"I maybe haven't thought about it but I'm contributing to that gap...whilst I very much am aware that I am trying to justify it's okay for me to go away and I'm not going to screw everybody over...for next year, I think that the underlying problem is there just not enough people. I think people taking a break is... relatively negligible to the fact that there just aren't enough bodies..."</i> (P6)
Use of locums	Working with locums was generally viewed unfavourably	<i>"Sometimes you can get people that are completely new to the specialty and healthcare around the UK or even healthcare at all and that can be more challenging. They're at my level and they're filling up a gap in my rota slot at my level but at the same time I find them depending on me...which can be a bit difficult."</i> (P16)

Personal life perspective

Work-life conflict: Some of the F2s described a poor work-life balance in their current NHS roles:

"I've missed friends' weddings, I've missed a christening, I missed my grandmother-in-law's funeral because I couldn't get the time off work." (P5)

They described an expectation that there would be less work-life conflict in their roles abroad:

"I've spoken to people who are doing A&E there [in New Zealand], and it's very similar, but, less hours. So, they normally do four days a week, whereas, right now, I'm doing seven. I'm on seven days right now, and I'm working from either two or three, 'till midnight, every day. Next week, I'm going straight into nights. So that's two weeks that I cannot have any social life. In New Zealand, I can do the job for four days a week, and then have a nice weekend off." (P4)

Work affecting health: The F2s also recounted times when work had negatively affected their own or others' health:

"She [another doctor] says the quality of life out there [in Australia] is so much better. She said when she worked here she was always stressed out, quite anxious as well... Then when she went out there she felt more supported and had enough time off to relax. She feels like she's absolutely a completely different person because her work life now doesn't affect her personal life." (P9)

Further examples are given in table 5.

Table 5: Personal life perspective

Subtheme	Details	Illustrative quote
<i>Work-life balance</i>		
Work-life conflict	Some of the F2s described a poor work-life balance in their current NHS roles	<i>"I've missed friends' weddings, I've missed a christening, I missed my grandmother-in-law's funeral because I couldn't get the time off work."</i> (P5)
	The F2s expected there to be less work-life conflict in their roles abroad	<i>"I've spoken to people who are doing A&E there [in New Zealand], and it's very similar, but, less hours. So, they normally do four days a week, whereas, right now, I'm doing seven. I'm on seven days right now, and I'm working from either two or three, 'till midnight, every day. Next week, I'm going straight into nights. So that's two weeks that I cannot have any social life. In New Zealand, I can do the job for four days a week, and then have a nice weekend off."</i> (P4)
Work affecting health**	The F2s recounted times when work had negatively affected their own or others' health	<i>"She [another doctor] says the quality of life out there [in Australia] is so much better. She said when she worked here she was always stressed out, quite anxious as well... Then when she went out there she felt more supported and had enough time off to relax. She feels like she's absolutely a completely different person because her work life now doesn't affect her personal life."</i> (P9)
Support in resolving work-life conflict	Some F2s had heard reports that it work-life balance was better supported in Australia, through better handover arrangements and support from consultants	<i>"It's easier to leave on time [in Australia], because you know there's someone there to handover to and your consultant is there saying, go home, is what I've been kind of told."</i> (P3)
	They perceived a lack of support from the NHS in helping to resolve work-life conflict	<i>"We know for a fact that we have three vacancies coming up in our rota, and they've done nothing to try and fill them, because in the end they're just going to email round us, rather than getting a locum... and the thing is we do, we do still fill it because we need to, the patients need us."</i> (P9)

Underlying theme

One theme spanned many of the different perspectives, and recurred through multiple narratives. This was the theme of “taking a break”. Examples are below:

A break from medical training (occupational):

“It seems that a lot of FY2’s that I know are quite burnt out, to be honest. People are tired of, I don’t know if it’s tired of working, but... you get into medical school and then it’s five or six years and straight into foundation training and then you’re probably working towards entering medical school for many, many years before you enter medical school. So everyone just seems to need time off.” (P12)

A break from being a doctor (occupational):

“I think the diploma in tropical medicine will probably be quite full on... but I’m not got people dying around me and having to sort them out, and then equally the six months of travelling is travelling, so I’m not going to be doing any work.” (P5)

A break from thinking about career progression (occupational):

“It’s also a break from having to think about your career too much, especially if you want to go into a competitive speciality. There can always be a pressure on you that it’s not just enough to do the day job -you have to get published, you have to do your audits, your posters, your presentations, there’s extra courses and working everything into your CV and just all that general stuff, whereas I think if you practice medicine abroad...well, I certainly don’t intend on pushing the seriously academic side of my CV too much when I just want to enjoy doing the job.” (P17)

A break from the NHS (organisational):

“I feel like I should have a break for a year and probably that will make me feel more enthusiastic about working in the NHS again afterwards.” (P1)

“I would just like to be away from this. And there are times, especially on my previous rota, where the job wasn’t as good, and I was working all the horrible hours, and having horrible situations, I was just like, it would be so nice to just not have this. So I think it’s just like a nice wee break.” (P4)

A break from the UK (personal life):

“I think it’s about going and exploring a brand new place and having the ideal time in your career to take that break.” (P9)

A break from working (personal life):

“I’m only moving at the end of August. And the prospect of having more than two weeks of holiday is pretty amazing, actually. So I guess, not a huge, long break, but at least, something that’s more than two weeks of holiday, is pretty good.” (P14)

A break from the “hum drum” of life (personal life):

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“You’re opting out of normal life... you’re just pleasing yourself and educating yourself and branching out. [At home] you just get bogged down in work and then stuff like having the flat means that you have to maintain the flat. There’s bills to pay. There’s just the hum drum life and you just you have to deal with it, whereas with travelling you’re just so much more free.” (P17)

A summary of the findings, showing the current work situation and the anticipated “break” are shown in figure 2.

DISCUSSION

In this study, we have used a framework provided by Feldman and Ng’s 2007 literature review⁹ to explore the reasons that F2 doctors choose to leave UK medicine after their F2 year. The use of this framework has allowed us to explore the breadth of their explicit reasons for leaving. Many of the subthemes identified resonated closely with the framework described by Feldman and Ng, summarised in figure 1. The subthemes for the structural, work-group and personal life perspectives were similar to the original framework, indicating similarities between then reasons that F2 doctors choose to leave, and those given by other professionals. The subthemes for the organisational and occupational perspectives were, however, quite different to the subthemes in the original framework. This may reflect some of the unique aspects of being an F2 doctor, and of working within the NHS, that may contribute to the decision to move abroad. These are discussed in further detail below.

The structural perspective

Obtaining work visas for Australia and New Zealand was perceived by participants as straightforward, whilst UK-trained doctors who were not UK nationals faced difficulties in obtaining a visa to stay in the UK. Given the large numbers of junior doctors now leaving the UK¹, the UK government could consider special arrangements to allow UK-trained doctors to stay should they wish. Previous research has suggested that in times of financial uncertainty, individuals are more risk averse and unwilling to leave.¹⁴ In contrast, the F2s in this study felt that the financial uncertainty brought about by the recent Scottish independence referendum and Britain’s decision to leave the European Union made this a good time to go abroad.

The organisational perspective

“Feeling valued” was an important concept for the participants. This related to staff perks, but also to working hours and being thanked for doing their job. Something as simple as having a dedicated space to go to during their breaks made doctors feel more valued, though in many hospitals the doctors’ mess has been abolished.¹⁵ This is reiterated in the literature on employee engagement. Seijts and Crim (2006) describe the *“Ten Cs of Employee Engagement”* as including connect (make employees feel valued), career (provide challenging and meaningful work with opportunities for career advancement), clarity (a clear organisational vision and goals), convey (provide feedback to employees on their performance), congratulate (thank and praise employees), contribute (help employees to understand the value of their contribution), control (give employees opportunities to control the pace and flow of their work), collaborate (provide opportunities to work in teams), credibility (maintain the good reputation of the company) and confidence (have leaders inspire confidence in their employees).¹⁶ Of these “Ten Cs”, several were brought up by the F2s. For example;

Connect: *“In Australia... they provide you with parking spaces, food, free tea or coffee...” (P2)*

Congratulate: *“It’s very rare to get a thank you” (P9)*

Collaborate: *"I think also it's been quite a lonely job because you are by yourself a lot of the time"* (P1)

The working environment and staff morale within the NHS were described as poor; *"It's just a horrible environment to work in"* (P8). Snow, 2002, argues that tackling work climate is the best way to retain more nurses within their jobs.¹⁷ She suggests addressing the six dimensions of organisational climate, as proposed by Litwin and Stringer.¹⁸ These include flexibility, responsibility, standards, rewards, clarity and team commitment.¹⁸ There are a lot of parallels between these criteria and the ten Cs, above. Notably, rewards (which could be as simple as verbal encouragement) were an important way to improve the work climate, and were identified by several F2s in the current study as lacking in the NHS.

The concept of *"non-handoverable job"* was interesting, and a possible reason for F2s staying later than their prescribed hours, and was potentially linked to them feeling undervalued. Taylor *et al.* (2013), conducted a grounded theory study to investigate reasons why residents in a Canadian institution chose to stay after their shifts had ended. They found that the dominant rationalisation was *"abiding by cultural norms."*¹⁹ They also found that in a *"relay-team structure"*, residents were likely to be able to *"pass the baton"* and go home, whereas when teams *"did not have the adequate redundancy in manpower"*, there was a tacit obligation to stay.¹⁹ In the case of foundation doctors, most handovers were given to a smaller Hospital At Night team, which may help to explain why they felt that it was not possible to hand over all of the remaining jobs.

The F2s made some worrying statements about their fears of raising concerns and about being penalised for doing so. They most often wanted to raise concerns about staffing levels, which is one of the most common whistle-blowing situations.²⁰ It is acknowledged that whistle-blowing is still often punished by the medical establishment, and the protection for whistle-blowers remains inadequate.²⁰

Whilst the foundation programme is intended to consist of largely workplace-based learning,²¹ the F2s in this study felt that it was important for them to have some formal teaching to support their on-the-job training. Providing a specific study budget was one way in which the F2s understood their training to be valued.

Most of the F2s did not have a mentor but would liked to have had one. Mentoring programmes have been shown to improve job embeddedness.²² Research on medical students with mentors showed that having a mentor gave a sense of security, gave hope for the future, increased motivation and increased the feeling of belonging in a community.²³

Some of the F2s identified a lack of formal careers advice. This was important as one of the key reasons for going abroad was not deciding on specialty choice, which might conceivably be improved with better careers advice. This has previously been identified as a weakness of the foundation programme.²¹

The occupational perspective

The proposed changes to junior doctor contracts in England provoked mixed emotions amongst the F2s. The changes were first proposed in July 2013, but negotiations stalled on multiple occasions, with the result that junior doctors in England undertook industrial action in December 2015, March 2016 and April 2016. Further negotiations in May 2016 led to a proposed change in the contract.¹⁰ These proposals made many of the Scottish F2s in this study wonder if they would return to the UK, due to fears that the changes would affect Scottish contracts in the future, and availability of specialty training jobs in Scotland due to competition from English trainees.

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4 The F2s described the development of multiple transferable skills. This is important, because
5 development of such skills is associated with higher levels of job mobility.²⁴ In some ways, the
6 skills that they had developed had prepared them better for further foundation jobs, rather than
7 necessarily preparing them to enter specialty training. The transition to core medical training was
8 viewed as particularly daunting. The aim of the foundation programme is to “*bridge the gap*
9 *between undergraduate and specialty training*”,²¹ but to date there have been no studies to
10 evaluate how effectively it does this.

11
12 Further study and research were cited as reasons for “*taking time out*”, as was having to choose a
13 specialty at an early stage. The foundation programme evaluation identifies flexibility within the
14 programme, as well as improved careers information and advice, as important recommendations
15 for the future of the foundation programme.²¹

16
17 F2s often cited a desire to step off the “*treadmill*” or “*conveyor belt*” of training. They expressed a
18 desire for individualised programmes, and viewed taking a “*year out*” as a way of providing an
19 individual element for themselves. The foundation programme evaluation highlighted a “*lack of*
20 *flexibility*” in the foundation programme, and a need to address this in the future.²¹

21
22 The foundation e-portfolio was viewed as a box-ticking exercise rather than as a useful opportunity
23 to improve their skills. This concurs with previous research, which finds that foundation doctors
24 consider the assessments to be “*excessive, onerous and not valued*”.²¹

25 26 **The work group perspective**

27
28 Loneliness at work, a lack of support from seniors, dysfunctional relationships and bullying at work
29 were all cited as reasons for lack of enjoyment in their foundation jobs. These are reflected in the
30 literature. For example, loneliness, reported by junior doctors in previous studies,²⁵ has been
31 associated with depression.²⁶ The foundation programme evaluation (2011) describes a “*repeated*
32 *theme of some trainees being asked to practise beyond their level of competence and without*
33 *adequate levels of supervision.*”²¹ Furthermore, a questionnaire study of 594 junior doctors found
34 that 37% reported being bullied in the previous year.²⁷ Most of the F2s reported having heard
35 about a utopic Australasian system in which there are higher staffing levels, good support and a
36 strong senior presence.

37
38 Bishop and Scott (1992) purport that task interdependence promotes stronger commitment to the
39 organisation as a whole.²⁸ The structure of UK training prevents F2 doctors working
40 interdependently with others. The structure of training is such that they must leave their current
41 role at the end of the year, and as such they will never be leaving their current colleagues ‘in the
42 lurch’. This may help to explain why none of the F2s expressed any guilt regarding leaving the
43 NHS.

44
45 In keeping with previous research, the use of locums was associated with poor satisfaction at
46 work.²⁹ However, rota gaps with no locum cover were associated with even greater levels of
47 dissatisfaction in the current study.

48 49 **The personal life perspective**

50
51 The desire to seek a better work-life balance was frequently cited by the F2s as a reason to leave
52 the UK. Some of the F2s also identified a negative impact of their work life on their health. Long
53 numbers of consecutive days and nights worked have previously been shown to be associated
54 with a poor work-life balance.³⁰

“Taking a break”

The original framework, provided by Feldman and Ng, explored reasons why people may choose to change their job. In the case of F2, we identified an underlying theme – a desire not to change their job but simply to “take a break” from various aspects of their lives. This theme may represent a level of burnout in junior doctors, who are at once trying to take a break from the UK, from working, from the “*hum drum*”, from medical training, from being a doctor, from thinking about career progression and from the NHS. High levels of burnout have been reported previously, with between 40-76% of junior doctors estimated to have experienced burnout.³¹ Many of the F2s do, however, state a clear intention to return to the UK after “*taking a break*”, bringing with them new skills and experience from their time abroad.

Limitations

This study explores the in-depth views of Scotland-based F2 doctors regarding their training experience and their ideas about junior doctor jobs abroad. We have explored their explicit reasons for leaving, as well as some factors known to increase job mobility, in order to uncover some of the hidden reasons for junior doctors leaving the NHS. There have not been any other qualitative studies exploring this phenomenon. We have used a constructivist approach, and have therefore produced results which do not attempt to predict the future, but instead explore the intricacies of decision-making,³² and provide a springboard for further areas of research.

We used a pre-existing framework to explore doctors’ reasons for leaving the UK. It is possible that through using this framework, we have overlooked some of the other reasons that F2s may have had for leaving. We have tried to minimise this risk by starting with very open questions about why they chose to leave and aiming specifically to find reasons that did not fit fully within the framework. We were open to exploring any reasons that did not fit within or contradicted the predefined framework with as much vigour as those that seemed to resonate with it.

All of the participants were working as F2s in Scotland. This was deliberate: At the time of this research, there was a great deal of uncertainty surrounding proposed changes to junior doctor contracts in England.¹⁰ There was anger and frustration relating to the proposed changes,¹⁰ and we felt that interviews with English trainees were likely to be very focussed on junior doctor contracts, and lacking in some of the other rich data that we have uncovered. Unlike positivist research, these results cannot be claimed to be *generalisable*, but instead may be *transferable* to other contexts. For example, issues such as lack of careers advice or mentorship programmes may not apply to every area in the UK, or the world, but may apply to some. Although only F2s working in Scotland were interviewed, we aimed to obtain as diverse a range of views as possible, by interviewing F2s from all four regions, of different ages, a mix of genders, and with different specialty interests and destinations in mind. The age range of volunteers was narrow (24-27), and did not include any graduate entrants, despite our attempts to recruit as diversely as possible. This might feasibly be because older F2s may be less likely to consider leaving the UK..

Junior doctors may have wanted to present a certain image of themselves to the researcher. We attempted to ameliorate this by using a non-threatening environment (participants were interviewed in their own homes via a video-link) and by ensuring anonymity. The researcher was also a doctor who had chosen to move abroad, thus reducing any threat of judgement towards participants.

Constructivism acknowledges that the researchers are biased. We do not try to minimise the bias, but instead reflect on the impact of the researchers’ preconceptions on the data.³² Four of the researchers are doctors, three of whom work in the NHS and one who has moved abroad. We therefore carry our own experiences of working in the NHS environment, and feelings about moving away, which may add richness to the data. Many of the comments made by the F2s

resonated with the report authors, and we were able to connect and relate to the F2s, especially when their experiences matched our own. We did not seek to simply support our pre-conceived views, but also to create new understanding about the driving forces behind F2s' decisions to leave.

Future research

This study has opened many avenues for possible future research. We were unable to recruit graduate entrants to this study, and their views could be useful sought in a further study. It would be interesting to follow the F2s into their new roles abroad, to find out if their expectations were met. It would be useful to explore their decision-making when deciding whether to return to the UK. The questions asked in this study could be posed from a more positivist perspective, perhaps by using this study as the basis for a questionnaire sent out to all F2s throughout the UK. We could consider conducting a similar study in other parts of the UK, to determine whether any of the results are transferable to other contexts. Finally, we could design, implement and evaluate a strategy, based on the results of this study, to encourage F2s to stay or come back to the UK.

Conclusions

The Feldman and Ng framework provides a helpful template for exploring the reasons that F2 doctors choose to leave UK medicine. Many of their reasons are similar to those given by any professional considering a change in their job (availability of jobs elsewhere; a desire to improve work-life balance; or a desire to enjoy better job perks). However, working within the NHS as an F2 doctor brought specific challenges: the rigidity of the training structures; the requirement to make a choice of specialty within the F2 year; exposure to workplace bullying; and difficulties in raising concerns. Despite these challenges, most of the F2s did not view their decision to leave as making a permanent job change, but as a temporary break from their current working lives.

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13 **Figure legends:**

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15 Figure 1: The six perspectives that influence career mobility versus embeddedness
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17 Figure 2: Synthesis of findings, showing the current work situation and anticipated "break"
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Structural perspective:
Macroeconomic conditions
Social and legal factors

Occupational perspective:
Gender
Wage levels
Labour intensity
Industry growth
Degree of change in occupational responsibilities
Human capital investments
Occupational networks
Rigidity and permeability of organisational structures

Organisational perspective:
Staffing and compensation
Pension plan and insurance
Social networks
Mentoring programmes
Organisational socialisation practices

Work-group perspective:
Social capital
Social support and group cohesiveness
Rational demography
Task interdependence
Virtual work
Use of external labour
Complementary versus supplementary person-group fit

Personal life perspective:
Amount and predictability of time demands
Support in resolving work-life conflict
Family and friendship networks

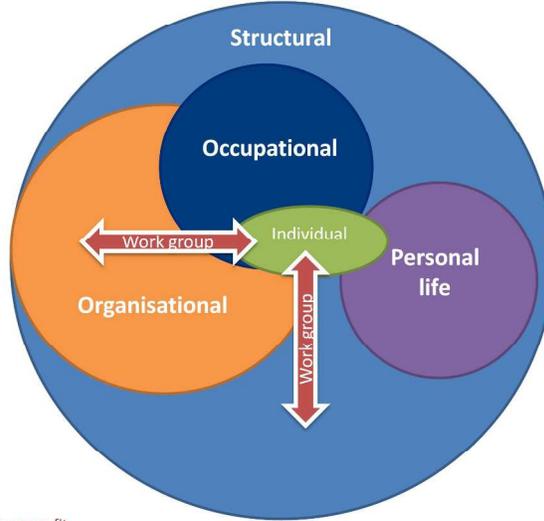


Figure 1: The six perspectives that influence career mobility versus embeddedness

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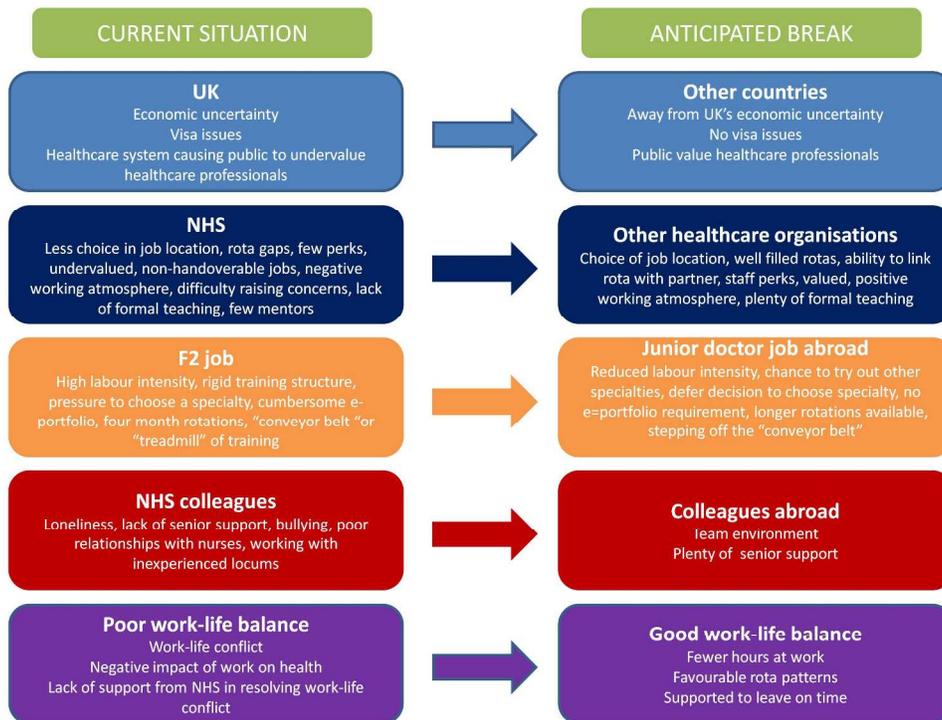


Figure 2: Synthesis of findings, showing the current work situation and anticipated "break"

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COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
<i>Personal characteristics</i>			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	5
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	5
Occupation	3	What was their occupation at the time of the study?	5
Gender	4	Was the researcher male or female?	5
Experience and training	5	What experience or training did the researcher have?	5
<i>Relationship with participants</i>			
Relationship established	6	Was a relationship established prior to study commencement?	5
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	5
Interviewer characteristics	8	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	23+24
Domain 2: Study design			
<i>Theoretical framework</i>			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	4
<i>Participant selection</i>			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	5
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	5
Sample size	12	How many participants were in the study?	6
Non-participation	13	How many people refused to participate or dropped out? Reasons?	6
<i>Setting</i>			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	6
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	6
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	6
<i>Data collection</i>			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	4
Repeat interviews	18	Were repeat interviews carried out? If yes, how many?	6
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	5
Field notes	20	Were field notes made during and/or after the interview or focus group?	5
Duration	21	What was the duration of the interviews or focus group?	6
Data saturation	22	Was data saturation discussed?	5
Transcripts returned	23	Were transcripts returned to participants for comment and/or	N/A

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
<i>Data analysis</i>			
Number of data coders	24	How many data coders coded the data?	6
Description of the coding tree	25	Did authors provide a description of the coding tree?	7-20
Derivation of themes	26	Were themes identified in advance or derived from the data?	5
Software	27	What software, if applicable, was used to manage the data?	6
Participant checking	28	Did participants provide feedback on the findings?	N/A
<i>Reporting</i>			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	7-20
Data and findings consistent	30	Was there consistency between the data presented and the findings?	7
Clarity of major themes	31	Were major themes clearly presented in the findings?	7-20
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	7-20

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

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